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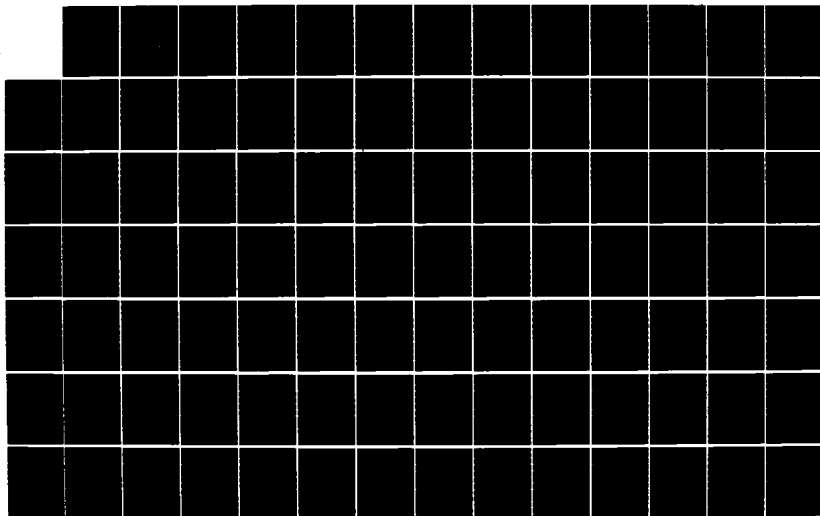
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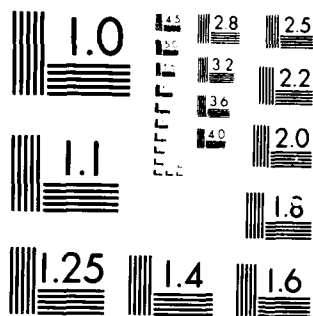
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## ABSTRACT

## THE BATTALION SURGEON: A BACKGROUND STUDY AND ANALYSIS OF HIS MILITARY TRAINING by Major Frederick E. Gerber.

This is a detailed study about the US Army Battalion Surgeon. Emphasis is devoted to the reasons the Battalion Surgeon was disestablished in the 1970-1980 timeframe, why the position was reestablished in 1984, and the implications for the future. The scope encompasses a review of the Battalion Surgeon's duties and how he has been trained, assigned and utilized since the end of World War I. The major objective of the study is to focus on the training the new Battalion Surgeon will require to perform his medical platoon leader duties.

Several findings and conclusions evolved from this study:

- History has accentuated the need for Battalion Surgeons on the front line "where the most significant improvement in mortality can be achieved."

- Since World War II the AMEDD has overextended itself in non-physician substitutions to alleviate physician shortages and physician reluctance to assume command and administrative assignments. As a result, physicians have lost their battlefield leadership and experience base over the past four decades.

- Historically, most Battalion Surgeons learned their military duties through trial and error; disastrous results were observed, and during combat this cost lives.

- Rhetorically, the need to provide physicians with military training has been fully recognized, yet historically, military training in the AMEDD has suffered general neglect because of the primary devotion to clinical training programs and concern over procurement and retention of physicians.

- History clearly reveals that the Battalion Surgeon must master numerous military subjects and "must be thought of and trained primarily as a soldier."

- The popular belief currently practiced by the AMEDD that physicians need only a modicum of exposure, training, and experience with the line to be prepared to lead or command at any level is completely unfounded. Although intuition and principles can be mastered by amateurs, medical support with its problems of treatment, evacuation, logistics and battlefield integration requires years of training and practice. Perhaps the greatest lesson is that it is "highly dishonest to reckon that insufficiently trained Battalion Surgeons will be effective in modern war."

This study concludes that the reintroduction of the Battalion Surgeon will require a reorientation of physician behavior, roles, leadership, and most importantly, military training.

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OF HIS MILITARY TRAINING**

A thesis presented to the Faculty of the U.S. Army  
Command and General Staff College in partial  
fulfillment of the requirement for the  
degree

**MASTER OF MILITARY ART AND SCIENCE**

by

**FREDERICK E. GERBER, MAJ, USA  
B.S., Pennsylvania Military College, 1973**

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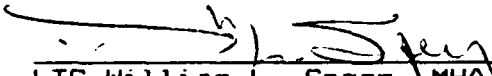
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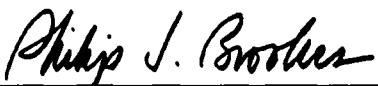
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The opinions and conclusions expressed herein are those of the student author and do not necessarily represent the views of the U.S. Army Command and General Staff College or any other government agency. (References to this study should include the foregoing statement.)

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This is a detailed study about the US Army Battalion Surgeon. Emphasis is devoted to the reasons the Battalion Surgeon was disestablished in the 1970-1980 timeframe, why the position was reestablished in 1984, and the implications for the future. The scope encompasses a review of the Battalion Surgeon's duties and how he has been trained, assigned and utilized since the end of World War I. The major objective of the study is to focus on the training the new Battalion Surgeon will require to perform his medical platoon leader duties.

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This study concludes that the reintroduction of the Battalion Surgeon will require a reorientation of physician behavior, roles, leadership, and most importantly, military training.



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## CHAPTER 1

### INTRODUCTION

#### Problem Statement

This study is about the Battalion Surgeon, a medical staff and leadership position of singular importance in providing battlefield medical support to the United States Army.

The purpose of this thesis will be to examine the Battalion Surgeon in detail. Beginning with his Colonial Army heritage, the Battalion Surgeon's position will be traced to the present. Special emphasis is given to the reasons the Battalion Surgeon was disestablished for over a decade in the 1970-1980 time frame, why the position was recently reestablished, and what impact it will have on the future.

The scope of this study will encompass a review of the Battalion Surgeon's duties and how he has been utilized, developed, and trained since the end of World War I.

The objective will be to focus on the training the newly reestablished Battalion Surgeon will require to perform the medical staff and leadership duties within the combat battalion he will be assigned.

## Background

### Legacy

The legacy of the United States Army Battalion Surgeon is over 200 years old and is founded in his ancestor, the Regimental Surgeon of the Colonial Army. Assigned to American colonial state militias, Regimental Surgeons provided military medical support to the Army during the French and Indian Wars (1754-1763).<sup>1</sup> With the official creation of the Continental Army Hospital Department on 27 July 1775, Regimental Surgeons began to officially provide battlefield medical support to the Continental Army, later to become the United States Army.<sup>2</sup> The Battalion Surgeon remained a traditional position in the US Army until shortly before the end of major American involvement in the Vietnam war in 1973.

### Declared Obsolete

The Battalion Surgeon was officially declared obsolete by virtue of the U.S. Army experience in the Vietnam war. Major General Spurgeon Neel, serving as the Army Deputy Surgeon General, prepared the official U.S. Army

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<sup>1</sup>U.S. Center of Military History, United States Army, The Army Medical Department 1775-1818 by Mary C. Gillett. 1981 ed. (Washington: Government Printing Office, 1981. (United States Historical Series).) p. 20. (Cited hereafter as Med Dept 1775-1818).

<sup>2</sup>CMH. Med Dept 1775-1818. pp. 22-49.

account of the Medical Department's activities in Vietnam during the years 1965-1970.<sup>3</sup> He concluded that:

Vietnam, and other recent experience in division and brigade medical support, has shown that it is no longer necessary nor desirable to assign medical officers to combat battalions. The impact of helicopter evacuation, frequently overflying battalion aid stations and going directly to supporting medical facilities, is only one of the considerations.<sup>4</sup>

The helicopter played a significant role in eliminating the Battalion Surgeon because it was able to evacuate casualties from the point of injury to a "suitable medical facility in the shortest possible time."<sup>5</sup> Studies of air evacuation missions performed in Vietnam showed the mean mission times to be 1 hour and 49 minutes with a median time of 64 minutes. These times were from the point of casualty occurrence until definitive treatment and classification at a hospital facility. Omitting the time required to make radio calls to schedule aircraft for missions, the mean evacuation time was actually 31 minutes.<sup>6</sup> Neel (1973) also reported short

---

<sup>3</sup>U.S. Department of the Army, Medical Support 1965-1970 by Spurgeon Neel. (CMH 90-16). Reprinted 1974. (Washington: Government Printing Office, 1973. (Vietnam Studies Series).) pp. iii-iv. (Cited hereafter as Medical Support 1965-1970).

<sup>4</sup>DA. Medical Support 1965-1970, p. 177.

<sup>5</sup>Ray Bonds, The Vietnam War: The Illustrated History of the Conflict in Southeast Asia (New York: Crown Publishers, Inc., 1979), p. 35.

<sup>6</sup>U.S. Department of the Navy, Office of Naval Research, Marine Corps Medical Evacuation Procedures



evacuation times, citing mean missions times of 1 to 2 hours and mean evacuation times, omitting radio calls, of 35 minutes.<sup>7</sup>

In addition to helicopter evacuation, Neel cited two additional factors that pointed to the obsolescence of the Battalion Surgeon. These were the "sophistication of medical equipment and facilities", networked throughout Vietnam, and "modern medical education and... medicine."<sup>8</sup> As for the later reason, Neel concluded that the modern physician depended heavily on laboratory tests, X-rays, and consultations with other physicians. Neel's observation was matched by Warner (1965) who described five role characteristics of the Battalion Surgeon. They were:

- 1: Work alone.
- 2: Non availability of extensive laboratory tests and X-ray facilities.
- 3: Lack of consultants.
- 4: Assumption of "total care of the patient".
- 5: Assumption of care other than pure medical i.e. morale, social problems, etc..<sup>9</sup>

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in Vietnam by Bernard J. Cameron and Harry J. Older of Bio Technology, Inc. (Project No 145-260; microfiche). Final report. (Falls Church, VA., 1970. (AD 869 148).) p. 9.

<sup>7</sup>DA. Medical Support 1965-1970, p. 70.

<sup>8</sup>DA. Medical Support 1965-1970, pp. 59 and 177.

<sup>9</sup>Allen Warner, "Acceptance of the Role of Battalion Surgeon," Military Medicine 130 (August 1965) pp. 783-85.

Apart from the medical reasons cited by Neel for the elimination of the Battalion Surgeon was the practical reality caused by the end of the doctor draft on 30 June 1973.

Beginning in the late 1960's and early 1970's, the Army experienced massive losses of career medical officers due to poor "conditions of employment."<sup>10</sup> Considering national predictions of critical physician shortages during this time period, the doctor draft was considered wasteful and an "inefficient consumer of medical talent."<sup>11</sup> Grimes (1976) cited not only the physician shortage as a contributing factor, but also the expanded role "para-medical" personnel, such as the Physician's Assistant, began to assume in the early 1970's.<sup>12</sup> Many factors exerted their influence on the decision to eliminate the Battalion Surgeon: a peacetime Army reducing its size; critical physician shortages in the shadows of a "zero draft"; an imbalance between generalists and

---

<sup>10</sup>Paul P. Brooke, "The Impact of the All-Volunteer Force on Physician Procurement and Retention in the Army Medical Department, 1973-1978," (MMAS Thesis, U.S. Army Command and General Staff College, 1979), p. 4. (Cited hereafter as Physician Procurement).

<sup>11</sup>Brooke, Physician Procurement, p. 29, citing Senate Armed Services Committee Hearings on the Uniformed Services Health Professions Revitalization Act of 1971, p. 16.

<sup>12</sup>Thomas F. Grimes, "The Role of the United States Army Surgeon: Past, Present, and Future" (MMAS Thesis, U.S. Army, Command and General Staff College, 1976), pp. 3-4.

specialists; "political interest in the health care crisis"; and emerging para-medical health care extenders.<sup>13</sup>

In practice, by 1970 and earlier, physicians were not being assigned to Battalion Aid Stations because of their underutilization.<sup>14</sup> By 1973, physicians were no longer officially assigned to H-series unit tables of organization and equipment. The Physician's Assistant replaced the physician as the medical practitioner at the battalion level. Medical Service Corps lieutenants, who had traditionally been assigned the role of administratively assisting the Battalion Surgeon, thus became the medical platoon leader. The traditional role of the physician as Battalion Surgeon became obsolete.

#### Decision to Reestablish

In 1984, steeped in historic tradition, the Battalion Surgeon reemerged as a prominent position in the Army medical support system. As the Army attempted to modernize for the 1990's and the 21st century, so did the

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<sup>13</sup>U.S. Department of the Army, U.S. Army Medical Department, Office of the Surgeon General, Historical Unit, Annual Report: The Surgeon General, United States Army, FY 1972. (Washington: Government Printing Office, 1972). p. 99. (Cited hereafter as Annual Report FY 1972).

<sup>14</sup>U.S. Department of the Army, U.S. Army Medical Department, Office of the Surgeon General, Historical Unit, Annual Report: The Surgeon General, United States Army, FY 1971. (Washington: Government Printing Office, 1971). p. 92. (Cited hereafter as Annual Report FY 1971).

Army Medical Department. Two major projects, concurrently developed, were responsible for reintroducing medical doctrine involving the Battalion Surgeon. The first project was medical support doctrine developed to support the Army's new Light Infantry Division. The second was a broad, bold, and comprehensive plan for the reorganization of the entire Army medical support system.

The Light Infantry Division was itself an old concept revitalized since its World War II experimental origins. In the 1980's, the Light Infantry Division was designed to "provide a strategically responsive, flexible, light division able to respond to a broad spectrum of conflict environments."<sup>13</sup> The medical structure designed to support the Light Infantry Division was called the "Modular Medical Support System". This system created a series of standardized teams or modules attempting to increase battlefield capability, mobility, and flexibility over the existing system.<sup>14</sup>

The Medical Platoon structure designed to support the maneuver battalion is shown in Appendix A. Medical support revolves around the Treatment Squad, within which

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<sup>13</sup>U.S. Department of the Army, Academy of Health Sciences, Interim Operation Concept: Medical Support in the Light Infantry Division. Draft. Rev 2. (Fort Sam Houston, TX: AHS, [by Oct 1984]). p. 1. (22 pages; provided by HSHA-CDB). (Cited hereafter as Interim Concept).

<sup>14</sup>AHS. Interim Concept, pp. 2-3.

an "Operational Medicine Physician (MOS 60)"--who will become the Battalion Surgeon--operates as both the Medical Platoon leader and director of Advanced Trauma Life Support to the supported unit.<sup>17</sup>

Another project, called the Medical System Program Review (MSPR), proposed changes to reorganize the entire medical system. Briefed to the Army leadership in December 1984, at the Academy of Health Sciences, Fort Sam Houston, Texas, the MSPR proposed, among other issues that the Modular Medical Support System be implemented in all types of divisions.<sup>18</sup>

Logic for the implementation was based on an "examination of military medical experience over the past 50 years" and cited nine "dicta regarding the practice of battlefield medicine."<sup>19</sup> Appendix B lists the dictums for background, but of importance to this thesis is the following:

Physician-directed care far forward on the battlefield ensures maintenance of the casualty's physiology thereby increasing the probability of his return to duty.<sup>20</sup>

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<sup>17</sup>AHS. Interim Concept, p. 4.

<sup>18</sup>U.S. Department of the Army, Academy of Health Sciences, Medical System Program Review. Final Ed. (Fort Sam Houston, TX: AHS, 1984). n.p. (Topic: Division Level Medical Support). (Looseleaf binder). (Cited hereafter as MSPR).

<sup>19</sup>AHS. MSPR, n.p. (Topic: Concept Base)

<sup>20</sup>AHS. MSPR, n.p. (Part II, Tab I).

The Medical System Program Review thus formally paved the way for reintroducing the Battalion Surgeon into the Army organizational structure.

#### New Perspectives

By 1984, new AMEDD leadership responsible for developing combat medical support concepts and doctrine caused the issue of physician assignment to the maneuver battalion to be reconsidered. Notably, lessons of the War of Attrition (1968-1971), the Arab-Israeli War (1973), and the Israeli-Palestine Liberation Organization (PLO) War (1982), heavily influenced the decision to reestablish the Battalion Surgeon position in the US Army. One acknowledgement of the Israeli influence was cited by the Commandant of the Academy of Health Sciences in an address to the Association of Military Surgeons of the United States.<sup>21</sup>

The Israelis introduced five basic principles of medical strategy from their lessons learned. They were:

I. The critical issue is not evacuation, but primary treatment and preparation for evacuation.

II. Medical treatment must be rendered as far forward as possible.

III. Shock must be avoided by early and massive perfusions of electrolytes.

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<sup>21</sup>Paul Smith, "Army Considers Treating Slight Wounds at Front Line, Evacuating Severely Injured," Army Times (3 December 1984) n.p. (Cited hereafter as Front Line).

IV. In the forward echelons, the medical services should be limited to resuscitation and definitive surgical treatment should be referred to fixed field hospitals in the rear.

V. All along the chain of evacuation the serious casualties should be accompanied by a medical team capable of preventing complications which might threaten life.<sup>22</sup>

Noted was the Israeli reliance on primary physician treatment far forward and preparation of casualties for evacuation, rather than immediate evacuation. Physicians, usually specialists, commanded the combat battalion medical platoon and their company/platoon medics treated all casualties before evacuation, contrary to the US Army practice of overflying these forward facilities.<sup>23</sup> Despite their doctrinal rhetoric, the Israelis did, however, air evacuate 80% of their casualties who had been prepared for evacuation by a physician.<sup>24</sup> Average evacuation times from the point of wounding until arrival at a definitive medical treatment site was 6 to 8 hours on the

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<sup>22</sup>U.S. Department of the Army, U.S. Army Medical Intelligence and Information Agency, Evacuation and the Medical Care of Casualties During the War of October 1973 by J. Adler. (USAMIIA-L-0122; microfiche). (Fort Detrick, MD.: USAMIIA, 1980. (AD B049 232L).) p. 1. (Cited hereafter as War of October 1973).

<sup>23</sup>USAMIIA. War of October 1973, p. 1.

<sup>24</sup>U.S. Department of the Army, U.S. Army Medical Intelligence and Information Agency, The Yom Kippur War and the Israeli Armed Forces Medical Corps by R. Forrissier and M. Darmandieu. (USAMIIA-K-6925; microfiche). (Fort Detrick, MD.: USAMIIA, 1977. (AD B016 772L).) p. 11. (Cited hereafter as Yom Kippur War).

Southern Front and 3 to 4 hours on the Northern Front during the October 1973 War.<sup>25</sup>

The liberal assignment of physicians down to the lowest level of basic combat units heavily influenced low Israeli casualty rates. Adler (1980) reported that by increasing the numbers of medical teams by a factor of four during the War of Attrition (1968-1971), the "number of KIA [killed in action] was reduced from 25.6% to 18.1%."<sup>26</sup> During the October War in 1973, Adler reported that 70% of the casualties received "initial treatment less than 60 minutes after suffering wounds."<sup>27</sup> Forissier and Darmandieu (1977) reported more optimistic times, citing casualties receiving their "first medical care in less than 20 minutes."<sup>28</sup> Armored first aid stations, consisting of company doctors riding inside of armored personnel carriers, were reported used in the October 1973 and Lebanon 1982 wars.<sup>29</sup> This concept was an effort on the part of the Israelis to project physician care far forward, a similar tenant of new US Army Medical

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<sup>25</sup>USAMIIA. War of October 1973, p. 3.

<sup>26</sup>USAMIIA. War of October 1973, p. 5.

<sup>27</sup>USAMIIA. War of October 1973, p. 5.

<sup>28</sup>USAMIIA. War of October 1973, p. 12.

<sup>29</sup>Richard A. Gabriel, Operation Peace for Galilee: The Israeli-PLO War in Lebanon (New York: Hill and Wang, 1984), p. 206. (Cited hereafter as Israeli-PLO War).



Department doctrine.<sup>30</sup>

In the Israeli armed forces, the general practice of medicine was clearly at the battalion level, whereas in the US Army, after the Vietnam war, it was at the brigade or regimental equivalent level.

#### Interim Developments

After the Battalion Surgeon was removed from the Army's medical support structure, his staff and medical platoon leader functions were taken over by a Medical Service Corps Officer. His clinical duties were assumed by a Physician's Assistant. Officer Professional development within the Army Medical Department was completely changed.

For over a decade, the onetime preeminent role of the physician in field medical units was shifted to the Medical Service Corps. An entire demigeneration of officers will be affected by the role reversal.

Physicians lost their leadership and experience base at platoon and higher levels. This is significant in that other branches of the Army place high significance on the "lieutenant [platoon level] phase" and leadership positions in troop units.<sup>31</sup> It is generally recognized and accepted that the platoon level of experience provides

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<sup>30</sup>AHS. MSPR, n.p. (Part II, Tab I).

<sup>31</sup>U.S. Department of the Army, Commissioned Officer

officers with an understanding of the Army operational environment and serves as the foundation for future service.<sup>32</sup>

The Medical Service Corps officer is no less affected than the physician. The 1970's generation of MSC officers have formed professional perceptions, attitudes, and career intentions based on over a decade's experience. A primal role of the MSC officer, from the 1970's to the present, was serving as the medical platoon leader and commander of most field medical units.<sup>33</sup> This trend was begun in the early 1970's, at the same time the Battalion Surgeon was removed, with the intention of relieving physicians from routine duties and to allow them to "see more patients and practice more rewarding medicine."<sup>34,35</sup>

The decision to place physicians back into maneuver battalion medical platoons will necessitate a reevaluation

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Professional Development and Utilization (Pamphlet 600-3). (Washington: Government Printing Office, 1984). p. 8. (Cited hereafter as Pam 600-3 (1984).)

<sup>32</sup>DA. Pam 600-3 (1984), p. 8.

<sup>33</sup>DA. Pam 600-3 (1984), p. 40.

<sup>34</sup>U.S. Department of the Army, U.S. Army Medical Department, Office of the Surgeon General, Historical Unit, Annual Report: The Surgeon General, United States Army, FY 1970. (Washington: Government Printing Office, 1970). pp. 85-86.

<sup>35</sup>DA. Annual Report FY 1972, pp. 99-100.

of the MSC officer professional development plan. It will also affect the MSC leadership base and the perceptions, operational outlook and career development of individual officers.

#### Summary

A tradition in the US Army since the Regimental Surgeon of the Colonial Army, the Battalion Surgeon officially served in front line combat units from 1775 until 1970.

The analysis of medical support provided in Vietnam indicated that Battalion Surgeons were no longer required. Helicopter evacuation, underutilization of physicians in the Battalion Aid Station, the orientation of physicians on modern medicine and the critical shortage of physicians, were some of the key factors contributing to the elimination of the Battalion Surgeon.

Lessons learned from the Israeli Army's experience in the Middle East wars since 1968, heavily influenced the US Army Medical Department to once again assign physicians as Battalion Surgeons.

Medical support concepts developed for the Light Infantry Division and the Medical System Program Review's overhaul of the entire Army medical support system both called for the reestablishment of the Battalion Surgeon.

After a decade's absence, the Battalion Surgeon will reappear in the frontline organizational structure of

the US Army. Physicians will once again perform the duties of a Medical Platoon Leader, a Battalion special staff officer and physician to a battalion of men. Unusual to this situation, the physician will possess higher military rank, but less professional military skill and training than the lower-ranked lieutenants working for and with him in both the platoon and battalion.

#### Research Question

What training will the Battalion Surgeon require to perform his duties as the Medical Platoon Leader?

#### Assumptions

Assumption 1: The fundamental assumption of this thesis is that the Surgeon General will actively assign physicians to combat maneuver battalions as Battalion Surgeons.

Assumption 2: Assigned as the Battalion Surgeon and medical platoon leader, physicians will actively perform associated duties within their assigned units. They will not serve token roles whereby they are assigned to the medical platoon but perform duty elsewhere.

Assumption 3: The current Army Medical Department Officer Orientation Course conducted for physicians does not prepare physicians to assume platoon leader duties.

### Definitions

AMEDD: The Army Medical Department (AMEDD) is comprised of six corps or branches of service within the Army. They include the Medical Corps (MC), the Dental Corps (DC), the Veterinary Corps (VC), the Medical Service Corps (MSC) the Army Nurse Corps (ANC), and the Army Medical Specialist Corps (AMSC).<sup>36</sup>

Basic Course: The basic course is a component of the Army military school system. In 1984, the Army defined the basic course as follows:

The basic course prepares newly commissioned officers for their first duty assignments with instruction on methods for training individuals, teams, squads and platoons. In addition, the course includes sufficient instruction to provide officers an understanding of the environment of the company/battery/troop including its tactics, organization and administration.<sup>37</sup>

Battalion Surgeon: The senior Medical Corps officer assigned as the medical platoon leader of a Battalion organization. The Battalion Surgeon performs the duties of a platoon leader, a Battalion staff officer and a physician.

Command: AR 600-20 states that "command of units, platoon level and above, normally is the responsibility of the senior regularly assigned officer present for

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<sup>36</sup>U.S. Department of the Army, Army Medical Department Officer Professional Development and Utilization (Pam 600-4). (Washington: Government Printing Office, 1977). p. 2-1. (Cited hereafter as Pam 600-4).

<sup>37</sup>DA. Pam 600-3, p. 11.

duty."<sup>38</sup>

Medical Corps: One of the six AMEDD Corps or branches.

It consists exclusively of commissioned officers who are qualified doctors of medicine or doctors of osteopathy. The Medical Corps encompasses those specialties filled by officers who are responsible for the professional care of the sick and injured. They maintain the health of the Army and conserve its fighting strength. Care is provided for the sick and injured in peacetime while, at the same time, preparations are made for health support of the Army in time of war.<sup>39</sup>

Medical Service Corps: One of the six AMEDD Corps or branches, the Medical Service Corps is comprised of 29 non-physician specialties ranging from administrative to direct patient care.<sup>40</sup>

Military Rank: Military rank is defined as:

The relative position or degree of precedence granted military persons which marks their station. It confers eligibility to exercise command or authority within the limits prescribed by law.<sup>41</sup>

Officer Professional Development: Professional development is the plan providing for the systematic training and progressive assignments of officers. The objective of professional development is to provide

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<sup>38</sup>U.S. Department of the Army, Personnel-General: Army Command Policy and Procedures (Army Regulation 600-20). (Washington: Government Printing Office, 1980). p. 3-1. (Cited hereafter as AR 600-20).

<sup>39</sup>DA. Pam 600-4, p. 6-1.

<sup>40</sup>DA. Pam 600-4, p. 8-1.

<sup>41</sup>DA. AR 600-20, p. 1-1.

officers with schooling, experience, assignments and promotions that will prepare them to accomplish both peacetime and wartime missions.<sup>42,43</sup>

Physician's Assistant: A non-physician, para-medical health care extender who is strictly trained to examine, diagnose and treat sick or wounded personnel under the guidance and supervision of a physician. By regulation, Physician's Assistants "will not be assigned any nonmedical duties of any type other than those for which specifically trained."<sup>44</sup>

Platoon Leader: The senior assigned officer present for duty within the platoon. The platoon leader commands the platoon and is responsible for everything the platoon does or fails to do.

### Limitations

A minor obstacle of this study resulted from the general lack of detailed and comprehensive documents specifically concerning the re-establishment of the Battalion Surgeon.

Current doctrine concerning the duties, skills

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<sup>42</sup>DA. Pam 600-4, p. 2-1.

<sup>43</sup>DA. Pam 600-3, p. 6.

<sup>44</sup>U.S. Department of the Army, Manual of Warrant Officer Military Occupational Specialties (Army Regulation 611-112). (Washington: Government Printing Office, 1984). p. 12.

selection, training, employment and implementation of the Battalion Surgeon is, for the most part, unavailable. Project officers at the Academy of Health Sciences, the proponent agency for doctrine concerning the new Battalion Surgeon, were unable to provide detailed documents and reports relative to this thesis topic.

This obstacle was generally overcome by the large body of literature found concerning the Battalion Surgeon prior to the time the position was disestablished.

#### Delimitations

This study restricted itself to historical data concerning the Battalion Surgeon developed since the end of World War I. Collection emphasis was placed on the following periods: World War II (1939-1945); Korean War (1950-1953); Vietnam War (1965-1973); Arab-Israeli War (1973); and the Israeli-Palestine Liberation Organization War (1982).

Clinical or physician specialty skills and training requirements are purposely discussed in broad, limited terms. The focus of this study is on military and platoon leading skills and training the Battalion Surgeon will need to perform his duties as a platoon leader.



## Significance and Need of the Study

### Introduction

The reintroduction of the Battalion Surgeon into the medical support system represents a significant potential for improving battlefield medical care and treatment. Major General William Winkler, Commandant of the Academy of Health Sciences, is largely responsible for the renovation of the entire medical support system to include reintroducing the Battalion Surgeon. In a presentation before the Command and General Staff College and the Association of Military Surgeons of the United States, he discussed the impact of a revamped medical support system.<sup>45,46</sup> Referencing an Army study, Maj. Gen. Winkler indicated that an equivalent of eleven combat maneuver battalions could be preserved and returned to battle during a European conflict. Winkler further indicated that "the medical system [as he proposes it] will serve as the principle source of replacement troops in the first 120 days of a conflict."<sup>47</sup> Winkler's system of medical support cannot be ignored, nor can the

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<sup>45</sup>Presentation by Major General William Winkler, at the Command and General Staff College, Fort Leavenworth, Kansas, September 1984.

<sup>46</sup>Smith, Front Line, n.p.

<sup>47</sup>Smith, Front Line, n.p.

contribution of the Battalion Surgeon within the proposed system.

Numerous questions and complex interlinking issues are surfaced by the reestablishment of the Battalion Surgeon. The Surgeon General, who is responsible for AMEDD officer management, development and training, will need to formally identify, then systematically address these issues.

Need. Is there a documented clinical or leadership need for physicians to be assigned to maneuver battalions? What evidence outdates the lessons learned in Vietnam which caused the elimination of the Battalion Surgeon? Are we prepared to accept the heavy casualties historically produced in physicians serving on the frontline? Do we have a sufficient peacetime or mobilization base of physicians?

Specialty. Should all or just selected physicians be trained for the Battalion Surgeon position? What Medical Corps job specialty should be targeted for assignment? Does the position call for a surgeon with one or two years of surgical training? Can an entry level General Medicine Officer greatly exceed the clinical capabilities of an experienced Physician's Assistant?

Procurement/retention. What are the longterm procurement, retention and career implications of assigning physicians to Battalion Surgeon positions? Will medical platoon administration requirements dilute physician

clinical skills and competence? Will competition for specialty training and certification give the Battalion Surgeon position a negative career connotation? Should the position be the premier, baseline position all future AMEDD physician leaders should serve in?

Medical Service Corps. Is there still a need for an MSC officer in the combat battalion medical platoon? If so, what will his role be and how will his specialty qualifications change? Should the focus of the MSC Officer Basic Course in preparing MSC officers to become platoon leaders shift to the MC Officer Basic Course? How will the MSC leadership base change?

Integration. How will high rank, entry level physicians be integrated into combat battalion medical platoons? How will physicians, as high ranked platoon leaders, relate to their more experienced, but lesser ranked lieutenant peers in the platoon?

#### Summary

As the Army Medical Department begins to restructure its medical support system, the impact and significance of reintroducing the Battalion Surgeon will be realized. A multitude of interrelated issues is developed.

Does the Army need really need the Battalion Surgeon? Who, what and how should he be trained? How will he be used and integrated into units? And how will they

affect the procurement, retention, and professional development of MC and MSC officers? All these questions require investigation.

Reintroducing the Battalion Surgeon is of momentous impact. The significance of this study is that I believe it will address the question fundamental to the success of the Battalion Surgeon. That is, "what training will the Battalion Surgeon require to perform his duties as the Medical Platoon Leader?"

#### Forecast of Subsequent Chapters

This thesis will be presented in four parts, represented by chapters.

Chapter 1, Introduction, has presented a general introduction and background for the problem to be studied.

Chapter 2, Survey of Literature, will report on the major bodies of medico-military literature relevant to the Battalion Surgeon. Three major bodies of literature were reviewed. First, the official historical records and reports developed on the Battalion Surgeon since the end of World War I. Second, the major books and periodicals that trace the development and utilization of physicians for battlefield medical support. And third, current Army doctrine concerning the professional training and development of officers.

Chapter 3, Findings, will focus on describing and analyzing the information produced from the survey of

literature in Chapter 2.

Chapter 4, Conclusions, will provide answers and conclusions to the research question. The significance of the thesis, its relationship to previous studies, and suggestions for further research will also be presented.

## CHAPTER 2

### SURVEY OF LITERATURE

#### Part I: THE BATTALION SURGEON

##### Introduction

The purpose of this thesis was to study and evaluate the professional utilization, development and training of the newly reinstituted Battalion Surgeon. Within the delimitations outlined in Chapter 1, a survey of literature was conducted from the period following World War I to the present. Evident in my research was the fact that the majority of writings pertinent to the topic evolved during this period. Beginning with the lessons learned during World War I, the literature findings were centered around American conflict involvement. Notably, World War II provided the largest, most diverse, and highest caliber of relevant readings. It produced detailed histories of the Army Medical Department in action. Notably, few reports of Army medical activities during the Korean War were found. Vietnam literature was better than that produced during the Korean War but not as in depth as World War II.

Literature of the medical support provided during the Arab-Israeli War in 1973 and the Israeli PLO War in 1982 was considered essential for review because of its obvious influence and impact on the evolution of current Army Medical Department medical support, to include the momentous decision to reintroduce the Battalion Surgeon.

Within the time period investigated, this thesis concentrated on three major bodies of medico-military literature which provided for the core of relevant findings. The first major body of literature reviewed included the official accounts, after action reports, lessons learned and other reports developed on the Battalion Surgeon. Books and periodicals that traced and emphasized the development, utilization and socialization of Battalion Surgeons formed the second body of literature reviewed. The third and final area surveyed was Army doctrine concerning the professional development and training of Army officers in general.

To satisfy the purpose of this study and given the three major bodies of literature reviewed, the Battalion Surgeon was investigated with the intention of developing a comprehensive understanding of his background, work environment, development, sociology, and training needs.

#### Definition

Finding a current, and official definition for the

Battalion Surgeon provided a good starting point for this thesis. The literature did not readily provide a definition, considering that the term "Battalion Surgeon" was not popularly used until after 1911, when the first maneuver division was formed. It should also be remembered that after 1970, the term had dissapeared completely from official Army terminology. Although numerous and diverse definitions of a "surgeon" were found, none satisfied the narrow parameters of this study. Therefore, the definition provided under Definitions in Chapter 1, Introduction, was formed from a composite of ideas expressed in the literature.

One of the first good definitions of a Battalion Surgeon found in the review of literature appeared in the Military Medical Manual.<sup>1</sup> The "Battalion or Squadron Surgeon" was defined as "the senior medical officer, usually a captain, assigned to duty with any battalion or squadron of the regiment..."<sup>2</sup> In 1942, one year into World War II, FM 8-10, Medical Service of Field Units, described the Battalion Surgeon as "the senior officer of

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<sup>1</sup>The Military Service Editors, Military Medical Manual (Harrisburg, PA: The Military Service Publishing Company [1940]), p. 551. (Cited hereafter as Medical Manual 1940).

<sup>2</sup>Medical Manual 1940, p.551.



the Medical Corps...attached [to a battalion]."<sup>3</sup>

In 1945, FM 8-5, Medical Department Units of a Theater of Operations, a reference to "command" was an important addition to the definition of the Battalion Surgeon. This Field Manual defined the Battalion Surgeon as follows:

The battalion section [platoon] is commanded by the senior officer of the Medical Corps assigned thereto and present for duty.<sup>4</sup>

During the Korean War, the command aspect of the Battalion Surgeon's position continued to be emphasized. As one illustration, the 7th edition of the Military Medical Manual emphasized that the medical officer, a physician, was both the battalion medical platoon commander and the battalion surgeon.<sup>5</sup>

After the Korean War, references to the Battalion Surgeon became difficult to find in the literature. This corresponded to Berry's (1964) observation of the growing and apparant disappearance of the "military surgeon,"

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<sup>3</sup>U.S. War Department, Medical Field Manual: Medical Service of Field Units (FM 8-10). (Washington: Government Printing Office, 1942). p. 49. (Cited hereafter as FM 8-10 (1942).)

<sup>4</sup>U.S. War Department, Field Manual: Medical Department Units of a Theater of Operations (FM 8-5). (Washington: Government Printing Office, 1945). p. 20. (Cited hereafter as FM 8-5 (1945).)

<sup>5</sup>The Military Service Editors, Military Medical Manual (Harrisburg, PA: The Military Service Publishing Company [1952]), p. 484. (Cited hereafter as Medical Manual 1952).

including the Battalion Surgeon.<sup>6</sup> Berry (1964) was one of the first authors I found to identify and correlate the noticeable reduction and deemphasis on military medicine, citing the "gradual disinclination" of Medical Corps officers to be known as "Military Surgeons," much less a "Battalion Surgeon."<sup>7</sup>

The Dictionary of United States Army Terms, reviewed from the years 1961 to the present, provided another interesting source of definitions which varied over the years. In 1972, the Army defined a surgeon as "the senior medical officer, in charge of the medical detachment or unit of a military organization or station."<sup>8</sup> By 1983, after the general disestablishment of the Battalion Surgeon in 1970, the Army had eliminated references of "command" and "in charge of." The surgeon was defined in 1983 as "the senior medical officer, usually a staff officer, who advises the commander on health services matters."<sup>9</sup>

This current Army definition, emphasizing the "staff officer" role, is similar to a definition provided

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<sup>6</sup>Bedford H. Berry, "The Military Surgeon - Will He Vanish?" Military Medicine 129 (January 1964) p. 28. (Cited hereafter as Surgeon - Will He Vanish?).

<sup>7</sup>Surgeon - Will He Vanish?, pp. 28-32.

<sup>8</sup>U.S. Department of the Army, Dictionary of United States Army Terms (AR 310-25). (Washington: Government Printing Office, 1972). p. 518. (Cited hereafter as AR 31-25 (date).)

<sup>9</sup>DA. AR 310-25 (1983), p. 253.

by Army Regulation 40-1, Composition, Mission, and Function of the Army Medical Department.<sup>10</sup> In its description of the duties of Medical Corps officers, AR 40-1 defined the surgeon as "the senior MC officer present for duty with a headquarters...officially titled...the surgeon..."<sup>11</sup>

Summary. The literature provided the background elements needed to compose the following modern definition of the Battalion Surgeon:

The Battalion Surgeon is the senior Medical Corps officer assigned as the medical platoon leader of a Battalion organization. He performs the duties of a platoon leader, a Battalion staff officer and a physician.

#### Duties and Responsibilities

"The most commonly known and spectacular duties of the medical officer involve the care of the wounded in battle. They are not, however, the most important."<sup>12</sup>

This extract from the Military Medical Manual best illustrated the character of literature findings, namely, that the Battalion Surgeon had both medical and military duties and responsibilities.

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<sup>10</sup>U.S. Department of the Army, Composition, Mission, and Function of the Army Medical Department (AR 40-1). (Washington: Government Printing Office, 1983). p. 2-1. (Cited hereafter as AR 40-1).

<sup>11</sup>DA. AR 40-1, p. 2-1.

<sup>12</sup>The Military Service Editors, Military Medical Manual, (Harrisburg, PA: The Military Service Publishing Company, 1940), p. 368. (Cited hereafter as Medical Manual 1940).

Based on the US Army's experience in World War I, medico-military writings in 1924 and 1925 generally described the basic duties and responsibilities of the Battalion Surgeon. The principle medical functions of the front-line physician serving as a Battalion Surgeon were identified as follows:

Provide first aid

Readjust dressings and bandages

Mark medical records

Sort casualties

Prepare casualties for further movement to the rear

Splint fractures

Administer morphine

Prevent shock

No operations performed; only emergency surgery (tracheotomy, ligation of an artery, etc.)<sup>13,14</sup>

Prior to and during involvement in World War II, the Battalion Surgeon's command, advisory, and administrative duties and responsibilities were also emphasized. From 1940 through 1945, the official duties of the Battalion Surgeon

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<sup>13</sup>"Our Military Policy and Organization for War," The Army Medical Bulletin 14 (1925) p. 40. (Publication of the Medical Field Service School). (Cited hereafter as Military Policy).

<sup>14</sup>"An Epitomized Description of Medical Service in Campaign," The Army Medical Bulletin 12:3 (1924) pp. 441-42. (Cited hereafter as Medical Service in Campaign).

as described in Army Field Manuals were:

(1) He obtains, from the battalion commander, the available information and tactical plan of the battalion. He makes a medical estimate of the situation and, when practicable, a reconnaissance of possible aid station sites...He submits the medical plan to the battalion commander for approval.

(2) He makes the necessary dispositions of the battalion section [platoon] based on the approved plan.

(3) He establishes the aid station when and where indicated, supervising its operation and personally assisting the care and treatment of casualties whenever necessary, devoting his attention mainly to the seriously wounded.

(4) He supervises the employment of the litter squads.

(5) He keeps in contact with the battalion commander and the forward planning of the battalion staff, and projects his own plan to correspond.

(6) He makes, or causes to be made, the necessary reconnaissances, when practicable, for relocation of the aid station.

(7) He keeps the battalion commander informed of the medical situation and makes the necessary recommendations for reinforcement of the medical service.

(8) He furnishes information to the regimental [brigade] surgeon and to the medical unit in immediate support, of the medical and tactical situation, including supply, in his front with such requests for special support or immediate evacuation of his casualties as may be necessary.

(9) He performs such other duties as the battalion commander may require.<sup>15, 16</sup>

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<sup>15</sup>War Department. FM 8-10 (1942), p. 50.

<sup>16</sup>War Department. FM 8-5 (1945), p. 550.

Additional duties of the Battalion Surgeon were found in the Military Medical Manual. These duties were:

(1) As a member of the staff of the regimental commander he advises that officer on medical and sanitary matters, all advice given or recommendations made to be in accord with the policies of higher medical authority.

(2) He supervises all training of the detachment and instructs the entire personnel of the battalion in personal hygiene, field sanitation, and first aid.

(3) He makes the sanitary inspections, supervising the sanitary procedures and precautions necessary to preserve the health of the command. He makes timely requisitions for all necessary equipment, including medical.

(4) He organizes the medical detachment [platoon] and plans its work so as to insure the accomplishment of its mission with the least possible disturbance to the arm or service which it serves.

(5) He keeps such records and renders such reports and returns as may be required.<sup>17</sup>

An additional perspective of the nature, duties, requirements, and philosophy of the Battalion Surgeon was provided by Conn (1942). In relating the command, staff, and clinical duties of the Battalion Surgeon, Conn (1942) wrote that the the Battalion Surgeon enjoyed "the most individualistic responsibility of any officer in the service."<sup>18</sup> Conn's observation was matched by

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<sup>17</sup>Military Medical Manual 1940, p. 550.

<sup>18</sup>Harold R. Conn, "The Battalion Medical Officer," The Army Medical Bulletin 61 (April 1942) p. 119. (Cited hereafter as Battalion Medical Officer).

Warner (1965) some twenty-three years later.<sup>19</sup> Conn's article is reproduced at Appendix C because I believe it represents the best single reading on the duties and responsibilities of the Battalion Surgeon.<sup>20</sup>

The duties of the Battalion Surgeon changed slightly after the rapid introduction of Medical Administrative Corps (MAC) officers as "Assistant Battalion Surgeons" in 1944.<sup>21,22</sup> MAC officers, reorganized in 1947 as Medical Service Corps officers, provided the majority of Army Medical Department replacements after the American invasion of France in 1944. Instead of the normal two MC physicians assigned to each combat battalion, there was one MC and one MAC, a non-physician. This savings in physicians positions made up the bulk of MC officer replacements for the rest of the European Theater of Operations for the duration of World War II.<sup>23</sup>

Although they were non-physicians, MAC officers

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<sup>19</sup>Allen Warner, "Acceptance of the Role of Battalion Surgeon," Military Medicine 130 (August 1965) pp. 783-85.

<sup>20</sup>Conn, "Battalion Medical Officer," pp. 119-123.

<sup>21</sup>U.S. War Department, U.S. Forces, European Theater, General Board, Training Status of Medical Units and Medical Department Personnel Upon Arrival In The European Theater of Operations (Report No. 88; mimeo). (West Germany, APO 0408: U.S. Forces European Theater, 1946. (CARL-R-12915.88).) p. 6. (Cited hereafter as Report No. 88).

<sup>22</sup>War Department. FM 8-5 (1945), p. 21.

<sup>23</sup>War Department. Report No. 88, p. 6.

generally possessed at least two years of clinical experience as prior non-commissioned officers.<sup>24</sup> The literature revealed that MAC officers routinely provided emergency medical treatment as part of their duties.<sup>25</sup> MAC officer substitutions as "Assistant Battalion Surgeons" was a successful program and exceeded the anticipated expectations of the Medical Department.<sup>26,27</sup> The substitution, however, freed up physicians for more clinical duties, while the MAC officer assumed more of the administrative duties.<sup>28</sup>

By the Korean War, the literature reflected the Battalion Surgeon had begun to delegate more of his duties to his MSC officer assistant. The 1952 Military Medical Manual provided the following insight into the evolving shift in duties:

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<sup>24</sup>James T. Tobey, The Medical Department of the Army: Its History, Activities and Organization (Baltimore, MD: The Johns Hopkins Press, 1927), pp. 86-7.

<sup>25</sup>War Department. FM 8-5 (1945), pp. 21-22.

<sup>26</sup>War Department. Report No. 88, p. 6.

<sup>27</sup>U.S. War Department, U.S. Forces, European Theater, General Board, Organization and Equipment of Medical Units in the European Theater of Operations (Study No. 89; mimeo). (West Germany; The General Board, 1946. (CARL-R-129.89-2).) p. 8. (Cited hereafter as Study No. 89).

<sup>28</sup>Spurgeon H. Neel, "An Accounting," U.S. Armed Forces Medical Journal 4:4 (April 1953) p. 625.



The battalion surgeon, being in command, must assume all responsibility for decisions and plans, but he may delegate such of his duties to his assistant [the Medical Service Corps officer] as he sees fit, according to circumstances and to the abilities of the latter. The medical officer will perform the bulk of the professional duties but the medical assistant, an officer of the Medical Service Corps, may be assigned to handle slightly wounded cases, assisting the battalion surgeon in any manner the latter may direct.<sup>29</sup>

Although the MSC officer performed some clinical functions within the battalion, the majority of his duties were administrative.<sup>30</sup> After the Korean War ended, all of the MSC officer's duties became administrative.

During the Vietnam War, the duties and responsibilities of the Battalion Surgeon remained very similar to the post World War I duties and responsibilities previously referred to. Mosebar (1968), however, elaborated on the changing role of the Battalion Surgeon in Vietnam.<sup>31</sup> Citing the extensive use of air ambulances to evacuate casualties in the Vietnam War, Mosebar (1968) discussed the growing concern of physicians over the medical inactivity of the Battalion Surgeon.<sup>32</sup> During Vietnam, Mosebar (1968)

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<sup>29</sup>Medical Manual (1952), p. 484.

<sup>30</sup>Medical Manual (1952), p. 484.

<sup>31</sup>Robert H. Mosebar, "The Role of the Battalion Surgeon in Vietnam," (USAWC Research Paper, U.S. Army War College, 1968), pp. 1-15. (Cited hereafter as Battalion Surgeon in Vietnam).

<sup>32</sup>USAWC. Battalion Surgeon in Vietnam, p. 8.

indicated that the Battalion Surgeon's primary duties were observed to be preventive medicine, field sanitation, mental health, medical training, and civic action.<sup>33</sup> Staff and medical operations functions were also mentioned.<sup>34</sup>

Summary. As reflected in the literature, the duties and responsibilities of the Battalion Surgeon have always encompassed command, staff (advisory and administrative), and clinical functions. As a physician, the Battalion Surgeon's clinical duties have been limited to simple, lifesaving procedures and monitoring the sorting and evacuation of casualties. Staff duties required the Battalion Surgeon to monitor, influence and report on the health of the unit personnel and operational environment. Lastly, as a commander, it was found that the Battalion Surgeon "must be a leader, responsible for the organization, training, direction and supervision of his personnel."<sup>35</sup>

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<sup>33</sup>USAWC. Battalion Surgeon in Vietnam, pp. 9-11.

<sup>34</sup>USAWC. Battalion Surgeon in Vietnam, pp. 11-13.

<sup>35</sup>Joseph W. Cooch, "What Is Military Medicine?" Military Medicine 133 (April 1968) p. 293.

### Selecting the Battalion Surgeon

Until his underutilization in the later portion of the Korean War and all of the Vietnam War, the Battalion Surgeon was considered a "key individual, both in the evacuation system...and in the command and administrative structure of his battalion."<sup>36</sup> The requirements and selection of physicians to fill the key position of the Battalion Surgeon was a matter studied and reported on in the literature.

Working with the War Department, the Preparedness Committee of the American Medical Association helped develop plans for supplying physicians to the Army.<sup>37</sup> These physician procurement plans were formally approved on 19 December 1941.<sup>38</sup> The Procurement and Assignment Service of the Federal Security Administration then set out to recruit physicians who could not be forced to accept military service.<sup>39</sup>

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<sup>36</sup>U.S. Department of the Army, Office of the Surgeon General, Report of the Surgeon General of the Ad Hoc Committee on Emergency Care of Casualties by Howard E. Snyder, Chairman, et al. (n.p., 1955). p. VI-I. (Cited hereafter as Snyder Report).

<sup>37</sup>George F. Lull, "Fifty Thousand Doctors and Half a Million Personnel," in Doctors at War, ed. Morris Fishbein (New York: E.P. Dutton & Company, Inc., 1945), p. 94. (Cited hereafter as Fifty Thousand Doctors).

<sup>38</sup>Lull, Fifty Thousand Doctors, p. 94.

<sup>39</sup>Lull, Fifty Thousand Doctors, p. 94.

Physicians who were interviewed would be given a physical examination, cleared by the attending official, and "commissioned on the spot."<sup>40</sup> Lull (1945) reported that this was the "first time in the history of the Army that commissions were ever issued in this manner."<sup>41</sup>

Lull (1945) reported that "almost every doctor" who was recruited or enticed to active duty "wanted to be assigned to a hospital," indicating that physicians took it as a reflection on their "professional [clinical] ability" if they received anything but a hospital assignment.<sup>42</sup> As will be reported in greater detail later in this study, physicians assigned to tactical units during World War II

were much disgruntled over the dearth of purely professional work. They did not want administrative duties; they wanted diagnosis, surgery and treatment of the sick.<sup>43</sup>

Attempts to rotate physicians during World War II between field units and hospitals resulted in a "mass of letters from doctors with tactical units requesting reassignment to hospitals."<sup>44</sup> Only two letters from physicians assigned to hospitals were received requesting

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<sup>40</sup>Lull, Fifty Thousand Doctors, p. 94.

<sup>41</sup>Lull, Fifty Thousand Doctors, p. 94.

<sup>42</sup>Lull, Fifty Thousand Doctors, p. 93.

<sup>43</sup>Lull, Fifty Thousand Doctors, p. 93.

<sup>44</sup>Lull, Fifty Thousand Doctors, p. 93.

field units.<sup>45</sup> Since the beginning of World War II, it appeared there were difficulties procuring the right types of physicians. The Surgeon General formally reported that the problems facing the Medical Department in post World War II years were

attracting the right type of doctor, in the right numbers to practice the right kind of medicine, in the right kind of a military setting.<sup>46</sup>

This statement, made in 1947, was to become prophetic for the years leading up to the obsolescence of the Battalion Surgeon twenty-three years later.

After World War II, the General Board published a series of reports on US Army operations conducted in the European Theater. The idea of the reports were to formally document the organization, training, equipment, and operational procedures utilized in the theater. The General Board's Report No. 88 commented on the training status of medical units and personnel upon their arrival in the war theater.<sup>47</sup> Report No. 89 elaborated on the organization and equipment of medical units in the theater of operations.<sup>48</sup> Relevant to this thesis, the General

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<sup>45</sup>Lull, Fifty Thousand Doctors, p. 93.

<sup>46</sup>R.W. Bliss, "The Army Medical Department Faces the Future," n.p., from speech delivered 5 November 1949: as reprinted in The Army Medical Bulletin 8 (January 1948).

<sup>47</sup>War Department. Report No. 88.

<sup>48</sup>War Department. Report No. 89.

Board reports provided the following information:

Medical officers...in many instances were not carefully selected for or trained to perform...tasks that were to be expected of them. The assignment of officer personnel presents two different problems: first, the professional qualifications required to fill the table of organization vacancy to which it is proposed to assign them; second, the physical, psychological, and training background necessary to fulfill their mission in a field unit.<sup>47</sup>

In commenting on the failure to carefully select medical officers for specific duties and responsibilities, the General Board provided the following guidance:

Adequate screening and classification of personnel should be made early in basic training so that at an early date specialist training can be instituted and the individual prepared for the position to which it is intended that he be assigned.<sup>50</sup>

As a result of the Korean War, the Snyder Committee (1955) was initiated to study the emergency medical care of casualties.<sup>51</sup> The Battalion Surgeon was a prominent position discussed by the report committee, which generally concluded:

We must select the best of our medical officers for division duty. We must train and develop them to appreciate the importance of their professional duty, and its military implication and application. And we must provide them with continuous, intensive and wise military professional counsel. Only then will we decrease the mortality forward of the hospital.<sup>52</sup>

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<sup>47</sup>War Department. Report No. 88, p. 2, 7.

<sup>50</sup>War Department. Report No. 88, p. 2.

<sup>51</sup>DA. Snyder Report, n.p.

<sup>52</sup>DA. Snyder Report, p. IV-19.

In studying who should be trained for the Battalion Surgeon position, the Snyder committee provided the following comments:

The primary duties of the Battalion Surgeon clearly place the job within the field of the specialty of surgery.<sup>53</sup>

The basic function of the Battalion Surgeon lies in combat. When the unit is not in combat, it is training for combat, and training personnel for surgical functions requires a surgeon.<sup>54</sup>

The Snyder committee expressed strong beliefs that the Battalion Surgeon should be a surgeon instead of a "general duty medical officer", and that he should have one or two years of formal training in surgery.<sup>55</sup> A consensus of opinion was also expressed that a special course of instruction [beyond basic training] for Battalion Surgeons should not be established.<sup>56</sup> Rather, the committee felt, "every military medical officer should receive military training peculiar to military service."<sup>57</sup>

Summary. The literature of World War II, the Korean, and Vietnam Wars provided an insight into the process and difficulties in selecting physicians for field

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<sup>53</sup>DA. Snyder Report, p. IV-9,10.

<sup>54</sup>DA. Snyder Report, p. IV-10.

<sup>55</sup>DA. Snyder Report, p. IV-10.

<sup>56</sup>DA. Snyder Report, p. VI-13.

<sup>57</sup>DA. Snyder Report, p. VI-13.

service as Battalion Surgeons. A prime consideration was that they be young, in tough physical shape, motivated for military service, and trained in battlefield surgery. As Conn (1942) reported, "no greater duty rests...than to see that...first line officers [referring to the Battalion Surgeon] are selected from men who have had some civilian traumatic experience."<sup>55</sup> Christy (1964) expressed the requirement that "we must have experienced military medical officers who know men, and their normal functioning under average operational conditions."<sup>56</sup>

#### The Battalion Aid Station

The literature provided an insight into the operational characteristics and design of the Battalion Aid Station, from which the Battalion Surgeon, by doctrine, has operated.

Medical experience from World War I greatly influenced the concept for employing the Battalion Aid Station for World War II.<sup>60</sup> Depending on the tactical or geographic situation, the Battalion Aid Station was designed to be emplaced 300-800 yards behind the front firing line

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<sup>55</sup>Conn, "Battalion Medical Officer," p. 120.

<sup>56</sup>Ralph L. Christy, "The Military Medical Officer in Support of Command and the Military Mission," Military Medicine 129 (March 1964) p. 242.

<sup>60</sup>MFSS. Medical Service in Campaign, pp. 430-31.



and in center of the supported unit.<sup>41,42,43</sup> This made service in the Battalion Aid Station a hazardous duty. During World War II, 90% of an Infantry Division's casualties occurred in the battalion areas.<sup>44</sup> With the exception of Vietnam, the significant hazards of service in the Battalion Aid Station remained constant, being last noted by the Israelis during the 1982 war in Lebanon.<sup>45</sup>

As the first facility behind the firing line, the Battalion Aid Station was established to treat casualties and prepare them for evacuation.<sup>46</sup> The idea was "based upon the principle that the sooner a wounded man receives adequate first aid and subsequent definitive surgery, the more successful are the results."<sup>47</sup>

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<sup>41</sup>Military Medical Manual 1940, pp. 562-63.

<sup>42</sup>MFSS. Military Policy, p. 39.

<sup>43</sup>Paul R. Hawley, "How Medicine in the European Theater of Operations Prepared for D-Day," in Doctors at War, ed. Morris Fishbein (New York: E.P. Dutton and Company, Inc., 1945). p. 197. (Cited hereafter as Medicine in Europe).

<sup>44</sup>U.S. War Department, HQ Army Ground Forces. Study of AGF Battle Casualties. (Washington, D.C.: HQ, Army Ground Forces, 1946. (CARL R-14620).) p. 2. (Cited hereafter as AGF Battle Casualties).

<sup>45</sup>Gabriel, Israeli-PLO War, p. 208.

<sup>46</sup>War Department. FM 8-5 (1945), p. 23-4.

<sup>47</sup>Fred W. Rankin, "American Surgeons at War," in Doctors at War, ed. Morris Fishbein (New York: E.P. Dutton & Company, Inc., 1945). p. 176. (Cited hereafter as American Surgeon).

The main purpose of the Battalion Aid Station was to provide first aid, make records, sort and prepare casualties for further movement to the rear.<sup>68,69,70</sup> The physician's role was to assess casualties; administer plasma or blood; stop the bleeding; apply or adjust dressings, bandages or splints; administer antibiotics; and finally, determine the priority of evacuation.<sup>71,72</sup> Any elaborate treatment at the Battalion Aid Station was warned against. The simplistic functions of the Battalion Aid Station matched the duties and responsibilities of the Battalion Surgeon.

Little equipment was needed. A study of battle casualties suffered in World War II by Army ground forces revealed that the Battalion Aid Station needed only the following equipment:

Dressings

Plasma

Sulfanilamide tablets/powder

Morphine

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<sup>68</sup>War Department. FM 8-5 (1945), p. 23.

<sup>69</sup>MFSS. Medical Service in Campaign, p. 40.

<sup>70</sup>Rankin, "American Surgeon," p. 178.

<sup>71</sup>Rankin, "American Surgeon," pp. 178-179.

<sup>72</sup>Hawley, "Medicine in Europe," p. 197.

### Splints<sup>73</sup>

Despite the proximity of a physician to the front line, the Battalion Surgeon and the Battalion Aid Station were not always used as they were intended.

During World War II, Battalion Aid Stations were often used to collect and load patients.<sup>74</sup> The treatment that was intended to be given at the Battalion Aid Station was delayed until the casualty reached the next level of medical care. The General Board cited that division first and second echelon medical facilities were "too frequently by-passed...in favor of higher level medical treatment facilities."<sup>75</sup> Hawley (1945), in contrast, reported that the "basic principle of swift evacuation is still the most satisfactory" allowing a wider use of trained physicians elsewhere.<sup>76</sup>

Concern for bypassed facilities was also evidenced during the Korean War. Westover (1955) cited examples of bypassing the Battalion Aid Station when medical evacuation means were available. Recognizing that although bypassing

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<sup>73</sup>War Department. AGF Battle Casualties, n.p.

<sup>74</sup>U.S. War Department, United States Forces, European Theater, General Board. Evacuation of Human Casualties in the European Theater of Operations (Study No. 92; mimeo) (n.p.: General Board, [by 1946].) p. 11. (Cited hereafter as Human Casualties).

<sup>75</sup>War Department. Study No. 88, p. 2.

<sup>76</sup>Hawley, "Medicine in Europe," p. 199.

the Battalion Aid Station was a departure from normal evacuation procedures, "it worked well."<sup>77</sup> Blumenson (1955) noted the tendency to move surgery as close to the patient as possible in World War II.<sup>78</sup> In the Korean War, however, he observed that this was considered undesirable because of the fluid tactical situation, limited, rough road network and rugged mountainous terrain.<sup>79</sup>

Rough terrain and the tendency to bypass the basic medical facilities of the Battalion Aid Station resulted in the predominant use of helicopters to evacuate patients.<sup>80</sup> The medical sentiment of the times were reported by Smith (1952) who indicated that the air evacuation of patients would undoubtedly replace other means of transportation.<sup>81</sup> Although the development of helicopter evacuation is widely attributed to the Vietnam conflict, the different tactics, maneuvers and terrain of the Korean War were more likely

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<sup>77</sup>John G. Westover, ed. Combat Support in Korea (Washington: Combat Forces Press), p. (Cited hereafter as Combat Support in Korea).

<sup>78</sup>Blumenson, in Combat Support in Korea, p.

<sup>79</sup>Blumenson, in Combat Support in Korea, p.

<sup>80</sup>George E. Armstrong, "Military Medicine in Korea," The Military Surgeon 110:1 (January 1952) p. 11.

<sup>81</sup>Allen D. Smith, "Medical Air Evacuation in Korea and Its Influence on the Future," The Military Surgeon 110:5 (May 1952) p. 332. (Cited hereafter as Air Evacuation in Korea).

responsible.<sup>82</sup> Like Vietnam, the helicopter contributed significantly to a decreased mortality rate at the expense of overflying and underutilizing the Battalion Aid Stations. Unlike Vietnam, however, the lessons of air evacuation learned from the Korean experience were interpreted much differently. In Korea, the Surgeon General noted that

the change that confronts the wound surgeon is not to protest this new development [helicopter evacuation and overflights], but to control it and adapt his art of wound management to what appears to be an entirely new pattern of time and space.<sup>83</sup>

The lesson provided by the Korean War allowed the Medical Department to formulate policies and plans that resulted in the full exploitation of air evacuation during the Vietnam War.<sup>84</sup> Its impact, however, directly contributed to the obsolescence of the Battalion Surgeon.<sup>85</sup>

Experiences of the Israeli Army during the Yom Kippur War in 1973 suggested a similar development of overflying the Battalion Aid Station. Nagan and Cordova (1982) and others observed that the "wounded are often transferred from the front to the interior without

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<sup>82</sup>Smith, "Air Evacuation in Korea," p. 323.

<sup>83</sup>Major General Churchill, the US Army Surgeon General, as quoted by Smith, "Air Evacuation in Korea," p. 326.

<sup>84</sup>Smith, "Air Evacuation in Korea," p. 332.

<sup>85</sup>Neel, Medical Support 1965-1970, p. 177.

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Summary. The Battalion Aid Station has historically been reported as the first echelon level of battlefield medical care. Its proximal location to the front line has made the Battalion Aid Station a dangerous work location. Simple functions have been traditionally assigned to the Battalion Aid Station to coincide with the duties and responsibilities of the Battalion Surgeon. These functions involved primarily, sorting, first aid, preparation of medical records and preparation of casualties for evacuation. Emergency life saving surgery has been the extent of any surgery performed at the Battalion Aid Station. The underutilization of the Battalion Aid Station was first recorded in World War II reports. Helicopter technology caused Battalion Aid Station overflights during the Korean and Vietnam Wars and was ultimately a contributor to the disestablishment of the Battalion Surgeon.

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•U.S. Department of the Army, U.S. Army Medical Intelligence and Information Agency, Medical Care and Evacuation of Wounded Soldiers--Policy and Organization During the Yom Kippur War by L. Nagan and M. Cordova. (USAMIIA-HT-002-B2; microfiche). (Fort Detrick, MD: USAMIIA, 1982. (AD B063 991).) pp. 4-6.

•7DA. Yom Kippur War, p. 11.

## CHAPTER 2

### SURVEY OF LITERATURE

#### Part II: PROFESSIONAL DEVELOPMENT

##### Organization

Prior to the US Army invasion of France in 1944, there were two physicians assigned to the Battalion Aid Station. A combat observation report rendered in September 1944 indicated that the task organization of "two physicians per infantry battalion was adequate."<sup>1</sup> By the winter of 1944-1945, however, the United States had "scraped clean the bottom of its manpower barrel."<sup>2</sup>

To accomodate this shortage of physicians, one physician in the Battalion Aid Station was replaced by a Medical Administrative Corps (MAC) officer, who became the Assistant Battalion Surgeon.<sup>3</sup> In 1946, an Army Ground Forces Technical Intelligence Report indicated that there were "no physicians needed at the Battalion Aid

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<sup>1</sup>U.S. War Department, U.S. Army Ground Forces, HQ Twelfth Army Group. Combat Observations (Immediate Report No. 53; mimeo). (n.p.: HQ, Twelfth Army Group, 1944). pp. 1-2. (Cited hereafter as Report No. 53).

<sup>2</sup>War Department. AGF Battle Casualties, n.p.

<sup>3</sup>War Department. Study No. 88, p. 6.

Station" because of the shortage of physicians in the hospitals.<sup>4</sup> It was reflected that "physicians complained of the lack of medical or surgical work that could be done at a Battalion Aid Station."<sup>5</sup> The report also mentioned that MAC officers performed well in the capacity of Assistant Battalion Surgeon.<sup>6,7</sup>

The Korean War began and ended with one physician and one Medical Service Corps--formerly MAC--officers assigned to the Battalion Aid Station.<sup>8,9</sup> After the war, the Snyder committee calculated that a line battalion of 1,000 men needed two physicians for "minimally adequate medical support".<sup>10</sup>

Whether or not a second medical officer is added to the battalion has no bearing on the lack of a requirement of a Medical Service Corps officer in the battalion; there is insufficient administration in a battalion medical detachment to warrant the waste of a commissioned officer to relieve the detachment

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<sup>4</sup>War Department, U.S. Army Ground Forces, HQ First Service Command. Technical Intelligence Report (Report No 1246; mimeo). (n.p.: HQ, First Service Command, 1945). p. 1. (Cited hereafter as Report No 1246).

<sup>5</sup>War Department. Report No. 1246, p. 1.

<sup>6</sup>War Department. Study No. 88, p. 6.

<sup>7</sup>War Department. Study No. 88, p. 8.

<sup>8</sup>Westover, Combat Support in Korea, pp. 109-10

<sup>9</sup>Medical Manual (1952), p. 484.

<sup>10</sup>DA. Snyder Report, p. VI-12.



[platoon] commander of minor administrative burdens.<sup>11</sup>

During the 1950's, when the US Army was experimenting with the Pentomic Division, each battle group--the equivalent of a battalion--was organized with one physician as the Battle Group Surgeon and one physician as the platoon leader.<sup>12</sup> There were no MSC officers assigned until later versions of the pentomic division were designed.<sup>13</sup>

Later, during the Reorganization Objectives Army Division (ROAD) configuration in 1961, the Battalion Aid Station had one physician and one MSC "Medical Operations Assistant" assigned.<sup>14,15</sup> This ROAD configuration provided the basic model for the Battalion Aid Station until the time the Battalion Surgeon was eliminated from the

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<sup>11</sup>DA. Snyder Report, p. VI-12.

<sup>12</sup>John Bullard, "Unit and Division Level Medical Service: Current Doctrine," p. 7. U.S. Department of the Army, Medical Field Service School, Report of the Fourteenth Army Medical Service Instructor's Conference. (Fort Sam Houston, TX: Medical Field Service School, 1964). (Cited hereafter as Current Doctrine).

<sup>13</sup>DA. Current Doctrine, p. 7.

<sup>14</sup>DA. Current Doctrine, p. 7.

<sup>15</sup>U.S. Department of the Army. Table of Organization and Equipment, 7G, Infantry Division (TOE 7G). (Washington: Government Printing Office, 1966). n.p. (Cited hereafter as TOE 7G).

H-series table of organization in 1970.<sup>16</sup> Physician's Assistants filled the clinical gap left by the physician beginning with their 1973 assignments to maneuver battalions.<sup>17</sup>

### Assignment

Prior to the outbreak of World War II, physicians, by policy, were sent to duty with troops after completion of the Basic Course at the Medical Field Service School in Carlisle Barracks, Pennsylvania.<sup>18</sup> In 1930, early specialization was not emphasized until the physician had developed a broad, general knowledge and experience base that came from serving with troops.<sup>19</sup> A 1935 article by the Army Surgeon General indicated that

It is only after a period of service with the of the Army that they [physicians] will become eligible at a later date to take professional post graduate courses either at the Army Medical Center or elsewhere.<sup>20</sup>

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<sup>16</sup>U.S. Department of the Army. Table of Organization and Equipment, 7H, Infantry Division (TOE 7H). (Washington: Government Printing Office, 1970). n.p. (Cited hereafter as TOE 7H).

<sup>17</sup>DA. TOE 7H, n.p.

<sup>18</sup>C.R. Reynolds, "The Training of Medical Officers at Service Schools," The Army Medical Bulletin 1:2 (April 1930) p. 6. (Cited hereafter as Training of Medical Officers).

<sup>19</sup>Reynolds, Training of Medical Officers, p. 6.

<sup>20</sup>Robert U. Patterson, "The Development of the Plan For Systematic Training of Officers of the Medical

Because of the immense surge of physicians inducted into the Army during World War II, not all physicians had the opportunity to serve with troop units. As will be shown later, physicians were hastily commissioned, trained, assigned to units and deployed to combat zones. The Army General Board cited several adverse affects of the wartime system which failed to assign Battalion Surgeons to tactical units until just prior to deployment:

- Lack of continuity of command
- Inadequate screening of personnel for assignment to medical units
- Lack of actual experience in caring for casualties
- Inadequate training in the tactics of the arm to which they were assigned<sup>21</sup>

Bliss (1948), the Army Surgeon General, reported that the morale of the military physician "was at a low ebb on V-J Day."<sup>22</sup> Young physicians were not readily enticed into service because of pay, promotion and assignments. Bliss (1948) indicated that clinical training was the key to attracting physicians to the Medical

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Department of the Army," The Military Surgeon 76:5 (May 1935) p. 229. (Cited hereafter as Systematic Training of Officers).

<sup>21</sup>War Department. Study No. 88, pp. 1-7.

<sup>22</sup>F.W. Bliss, "The Future of the Army Medical Department," The Military Surgeon 102:4 (April 1948) p. 300. (Cited hereafter as Future of the AMEDD).

Corps.<sup>23</sup> This concept, which originated after World War II, was the beginning of elaborate clinical training programs for physicians, still present today.

There was significant pressure on the Army Medical Department to reduce the numbers of physicians assigned to tactical field units after World War II. The Snyder report noted that the civilian and military medical profession had been urging a "dangerous further reduction in the number of medical personnel [physicians] in the division" during and after the Korean War.<sup>24</sup> One of the Snyder committee's conclusions, pertaining to the assignment of physicians, was:

The separation of career patterns for medical officers into purely clinical or staff and command channels has weakened the ability of the Army Medical Service to execute its mission in war.<sup>25</sup>

The Snyder commission recommendation to correct this observation was:

Amend the career patterns of medical officers to provide integration of staff, command and professional [clinical] functions through the (temporary) grade of Lieutenant Colonel.<sup>26</sup>

A decade later, Berry (1964) began to report on the disappearance of surgeons who apparently were not routinely

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<sup>23</sup>Bliss, Future of the AMEDD, p. 301.

<sup>24</sup>DA. Snyder Report, p. 1.

<sup>25</sup>DA. Snyder Report, p. IX-2.

<sup>26</sup>DA. Snyder Report, p. X-1.

being assigned to combat field units.<sup>27</sup> Medical Corps officer shortages had begun to influence personnel assignments. Physicians were being assigned predominantly to clinical or research assignments. Command and staff assignments were unattractive to physicians and went largely unfilled at the battalion level.

Although the Snyder commission had recommended against physicians becoming either field or non-field oriented, Berry (1964) recommended the opposite.<sup>28,29</sup> Berry stated:

A well balanced Military Medical Service requires two components - first, a large group of physicians well qualified in general practice and in the specialties, and second, a segment interested and proficient in the military and the various aspects of organization, tactics and strategy. They must be able to understand and advise their commanders and line associates wisely and to exert qualities of sound leadership.

This does not preclude their being good doctors in their specialty of choice, but because of their interest in and further study of military problems, they can become true Army officers as well.<sup>30</sup>

Berry (1964) recommended that physicians interested in a military--as opposed to a clinical--career, spend

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<sup>27</sup>Berrey, Surgeon-Will He Vanish?, p. 28.

<sup>28</sup>DA. Snyder Report, p. VI-13.

<sup>29</sup>Frank B. Berry, "The Status of the Medical Officer: His Training and Employment," Military Medicine 129:3 (December 1964) p. 1130. (Cited hereafter as Status of Medical Officer).

<sup>30</sup>Berry, Status of Medical Officer, p. 1130.

18-24 months as a Battalion Surgeon to learn "the basic military problems of the soldier."<sup>31</sup>

Despite the bias expressed for clinical assignments since the end of World War II, the official guidance of the Medical Department was better rounded. The literature suggests that at least until 1970, when the Battalion Surgeon was disestablished, all physicians could "expect assignments in clinical, staff and command positions at various levels throughout their careers."<sup>32</sup> A gap in the published assignment policy for AMEDD officers occurred in Army literature between 1970 and 1977. When DA Pam 600-3 (Commissioned Officer Professional Development and Utilization) was updated in March 1974, the AMEDD, being a special branch of the Army, was not discussed. It was not until 1977 that a professional development pamphlet for AMEDD officers was published.<sup>33</sup> It reflected a major shift from all previous assignment strategy. From 1977 to the present, the physician's "Basic Professional Development Period," (0-7 years), was designed to "enable the physician to develop in a primary clinical specialty."<sup>34</sup>

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<sup>31</sup>Berry, Status of Medical Officer, p. 1130.

<sup>32</sup>DA. Pam 600-3 (1970), pp. 7-66,67.

<sup>33</sup>DA. Pam 600-4, p. 6-2.

<sup>34</sup>DA. Pam 600-4, p. 6-2.

### Training and Education

The method used to train, and educate the Medical Department officer--key aspects of this thesis--were discussed throughout the historical literature reviewed. To me, it represented the most interesting aspect of the Battalion Surgeon's career development. Who, what, and how to train, followed by where, when, and why. Throughout its existence, the Army Medical Department has developed, changed, and evolved its own process for training medical personnel.

Colonel John Van Rensselaer Haff organized the first system of training for the Hospital Corps in 1891.<sup>35</sup> Attempting to modernize the American medical forces of the times, Haff had an underlying belief that the

Medical soldier required as much training, including drill practice and field exercises, as did any other soldier, but that he should be trained in medical techniques as a plus.<sup>36</sup>

In 1893, Sternberg, the Army Surgeon General, founded the Army Medical School.<sup>37,38</sup> Sternberg

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<sup>35</sup>Eloise Engle, MEDIC: America's Medical Soldiers, Sailors and Airmen in Peace and War (New York: John Day Company, 1967), p. 32. (Cited hereafter as MEDIC).

<sup>36</sup>Engle, MEDIC, p. 32.

<sup>37</sup>Patterson, Systematic Training of Officers, pp. 229-46.

(1893) outlined the need for medico-military training by stating:

Although there is no need to teach medicine or surgery to well educated graduates of our medical colleges, there are certain duties pertaining to the position of an army medical officer for which the college course...has not prepared them; and certain of these duties are more important than the clinical treatment of individual cases of disease and injury because the efficiency of a command, of an army even, may depend upon their proper performance.<sup>39</sup>

Patterson (1935) stated that Sternberg's efforts in creating the Army Medical School was "intended to convert the newly appointed physicians into qualified Medical Officers."<sup>40</sup>

The Army Medical School evolved to provide technical and clinical medical skills to the physician. It supplemented the training officers received in medical school and emphasized the special nature of Army medical practice.<sup>41</sup> Training centered on "preventive medicine, military surgery, roentgenology, laboratory work, tropical disease, psychiatry, and eye, ear and throat

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<sup>39</sup>James T. Tobey, The Medical Department of the Army: Its History, Activities and Organization (Baltimore, MD: The John Hopkins Press, 1927) pp. 24-25. (Cited hereafter as Medical Department of the Army).

<sup>39</sup>Sternberg, Annual Report: The Surgeon General of the United States Army, 1893, as cited by Robert U. Patterson, The Military Surgeon 76:5 (May 1935) pp. 232-33.

<sup>40</sup>Patterson, Systematic Training, p. 233.

<sup>41</sup>Reynolds, Training of Medical Officers, p. 5



specialties.<sup>42</sup>

Although the Medical Department had made great strides to improve the medical training of its officers, there was little interest developed within the Medical Department "on the subject of the duties and functions of the medical service in campaigns."<sup>43</sup>

American history reflects that the Army Medical Department entered all wars prior to World War I virtually unprepared.<sup>44</sup> The end of the Spanish-American War in 1898 saw the first serious medico-military training improvements initiated.<sup>45</sup> This post war effort allowed the US Army to enter World War I--for the first time--with a sound medical force. The Selective Service Act of 1917 was successful in that the Army received and trained over three million men in a two year time span.<sup>46</sup> But despite the success of the 1917 draft, it was shown that

A proper and effective medical...service for such an Army cannot be fashioned with equal rapidity from an inexperienced and unprepared corps of physicians

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<sup>42</sup>Reynolds, Training of Medical Officers, p. 5

<sup>43</sup>Patterson, Systematic Training, p. 236.

<sup>44</sup>H.L. Gilchrist, "Our Camps of Instruction," The Military Surgeon 83:2 (August 1938) pp. 174-76. (Cited hereafter as Camps of Instruction).

<sup>45</sup>Gilchrist, Camps of Instruction, p. 174-76.

<sup>46</sup>Tobey, Medical Department of the Army, p. 28.

thus suddenly called from their civilian pursuits.<sup>47</sup>

This was a prophetic conclusion of the World War I experience.

The Medical Department established the Medical Field Service School at Carlisle Barracks, Pennsylvania, in 1920.<sup>48</sup> "The need for such a school, where medical officers could be taught the military side of their work, had been apparant since the war [World War I]."<sup>49</sup> Here, physicians attended a five month Medical Department Officer Basic Course.<sup>50</sup> This course emphasized "tactics, logistics, administration, field sanitation, and instructional methods."<sup>51</sup> The Basic Course was intended to prepare physicians for their administrative and tactical duties and prepared the "foundation for their future service in command and staff positions."<sup>52</sup>

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<sup>47</sup>Albert G. Hulett, "Medical Preparedness: Every Doctor's Responsibility," The Military Surgeon 83:5 (November 1938) p. 440.

<sup>48</sup>U.S. Department of the Army, U.S. Army Medical Department, Office of the Surgeon General, Medical Training in World War II by Robert J. Parks. (Washington, D.C.: Government Printing Office, 1972. (Administrative series of the Medical Department of the United States Army in World War II).) p. 5. (Cited hereafter as Medical Training in World War II).

<sup>49</sup>Tobey, Medical Department of the Army, p. 47.

<sup>50</sup>DA. Medical Training in World War II, p. 6.

<sup>51</sup>DA. Medical Training in World War II, p. 6.

<sup>52</sup>Reynolds, Training of Medical Officers, p. 5

Major General Robert Patterson, Surgeon General of the Army, described the systematic training of Medical Department officers inaugurated in 1933.<sup>83</sup> The "new system," as Patterson (1935) described it, required that all Medical Department officers

...shall be ordered to pursue a course of basic military training at the Medical Field Service School at Carlisle Barracks, Pa., before they are assigned to permanent stations for duty, and that it is only after a period of service with the line of the Army [at least one year] that they will become eligible at a later date to take professional post graduate courses either at the Army Medical Center or elsewhere.<sup>84</sup>

A schematic that illustrates the process for training Medical Officers in the 1930's is shown in Appendix D.

Reflecting on the Medical Department's past history, Patterson (1935) indicated that for

...many decades in our instruction it had been the poor practice to 'put the cart before the horse,' that is to give the basic military training after instead of before the professional post graduate course.<sup>85</sup>

In some instances, Patterson (1935) noted that some officers "never received any basic military training."<sup>86</sup> Patterson also expressed his concern for the numbers of medical officers who did not fully appreciate that:

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<sup>83</sup>Patterson, Systematic Training, pp. 229-46.

<sup>84</sup>Patterson, Systematic Training, p. 229.

<sup>85</sup>Patterson, Systematic Training, p. 229.

<sup>86</sup>Patterson, Systematic Training, p. 229.

One of the most important missions of the Medical Department of the Army is the training of its officers so that they will be capable at all times to meet the obligations incident to service in the field, as well as the professional requirements which are the responsibility of the Medical Department.<sup>57</sup>

Military training in the 1930's was not only considered important, it was necessary for the preparation and successful completion of promotion examinations.<sup>58</sup>

World War II caused drastic modifications to the Army Medical Department's system for training. The requirement for large numbers of physicians to be placed into duty positions in the shortest possible time directed the implementation of short, intensive orientation courses.

Prior to the American declaration of a limited emergency in September 1939, the Medical Field Service School offered the 5-month Basic Course for newly commissioned physicians.<sup>59</sup> After a limited emergency was declared, however, the courses offered at the Medical Field Service School became abbreviated.

In 1940, large classes of medical officers were given a 1-month training course at the Medical Field Service School to meet the war emergency.<sup>60</sup> During this

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<sup>57</sup>Patterson, Systematic Training, p. 231.

<sup>58</sup>Patterson, Systematic Training, p. 231.

<sup>59</sup>Albert S. Dabney, "The Work of the Medical Field Service School," The Military Surgeon 92:2 (February 1943) p. 180. (Cited hereafter as Medical Field Service School).

<sup>60</sup>Dabney, Medical Field Service School, p. 180.

same time period, Fox (1941) reported finding a lack of qualified battalion surgeons in the field.<sup>61</sup> The 1-month training course was apparently found to be insufficient to prepare physicians for field duty. Dabney (1943) reported that it was the opinion of the time that "fewer Medical Department officers, with a more comprehensive training, would be of more value than a great number with less training."<sup>62</sup> Consequently, the basic course was increased to a 2-month course in 1941.<sup>63</sup> Although the 2-month course was considered "very satisfactory to the student and to [the faculty]." The increasing demands of World War II caused the War Department to again reduce the basic course to a 1-month course.<sup>64</sup> The 1-month course was considered "very intensive" and operated "six days a week, eight hours a day, with some hours of instruction in addition, at night."<sup>65</sup> The course, even during the war, required students to complete the course requirements "as evidenced by examination."<sup>66</sup>

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<sup>61</sup>Leon A. Fox, "The Medical Officer's Responsibility in the Present Emergency," The Army Medical Bulletin (January 1941) p. 77.

<sup>62</sup>Dabney, Medical Field Service School, pp. 180-81.

<sup>63</sup>Dabney, Medical Field Service School, pp. 180-81.

<sup>64</sup>Dabney, Medical Field Service School, pp. 180-81.

<sup>65</sup>Dabney, Medical Field Service School, p. 181.

<sup>66</sup>Dabney, Medical Field Service School, p. 181.

During World War II, the objectives of the Medical Field Service School were:

To instruct and train Medical Department officers in the principles and methods of medical field service so as to increase their ability as instructors and to enhance their proficiency in the performance of their command and staff duties.<sup>67</sup>

Various reports generated after World War II provided an indication of the success achieved by the Medical Field Service School and its basic course for physicians. Asherman (1945) reported on Medical Department activities in the Mediterranean and European theater of operation.<sup>68</sup> The need for medical units to train in medical and tactical subjects was emphasized.<sup>69</sup> A report of the Army General Board commented on the training of medical department units and personnel in the European theater. The General Board indicated the following:

[Medical Department officers] in general received adequate training in the Medical Field Service School but unfortunately this training was not available to most officers immediately after their entrance upon active duty. As a result, they had formed bad habits

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<sup>67</sup>Joseph R. Darnell, "A General Perspective of the U.S. Army Medical Service," The Army Medical Bulletin 61 (April 1942) pp. 155-56.

<sup>68</sup>U.S. War Department, Office of the Surgeon General, Report of Medical Department Activities in Mediterranean Theater of Operations and European Theater of Operation. (Washington: Office of the Surgeon General, 1945) n.p. (Cited hereafter as European Theater).

<sup>69</sup>War Department. European Theater, n.p.

prior to receiving this training and these habits were difficult to correct.<sup>70</sup>

The General Board's report further cited that poorly trained enlisted personnel were often observed in separate companies "which were frequently commanded by young and inexperienced medical department officers."<sup>71</sup> Having observed the products of medical department training during World War II, the General Board recommended the following:

Basic training should be given all medical department personnel immediately after they enter the military service. This is particularly true of the officers in the medical department who, if they do not receive this basic training immediately after they enter upon active duty, are apt to form undesirable habits which are very difficult to eradicate later in their military service...Medical Department officer replacement training should add emphasis to tactics (of the arms as well as medical tactics) instead of technical medical training.<sup>72</sup>

An Army Ground Forces study conducted to determine the lessons to be gained from a study of World War II battle casualties revealed the following:

Casualty data supports the popular belief that every division, when first committed to action, goes through an inevitable and expensive shake down period. Many casualties were incurred because partially trained replacements had to be thrown into the front lines before they could be assimilated by their own units.<sup>73</sup>

This finding by the Army Ground Forces supported

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<sup>70</sup>War Department. Study No. 88, p. 4.

<sup>71</sup>War Department. Study No. 88, pp. 1-2.

<sup>72</sup>War Department. Study No. 88, pp. 2,8.

<sup>73</sup>War Department. AGF Battle Casualties, p. 8.

Duke's (1948) contention that physicians,

...regardless of what type of professional work they do in peacetime, should receive sufficient tactical, administrative and staff training so that in wartime they may be capable staff officers, medical planners and commanders.<sup>74</sup>

At the end of World War II, the Medical Department faced new problems which required changes in the training system. Most Regular Army physicians had served in command and staff positions during World War II, allowing drafted civilian physicians to perform most of the clinical work. This followed a "theorem" practiced by the Medical Department even before World War I.<sup>75</sup> Patterson (1935) summarized this practice as follows:

In time of war no trained medical officer of the Regular Army can be spared to engage in the actual practice of his profession, but that his duties will be almost entirely of an administrative nature in the direction and supervision of officers of the civilian components of the Army, who will do the actual professional work.<sup>76</sup>

Regular Army physicians were generally out of touch with clinical education and training at the conclusion of World War II. The Medical Department faced the problems of having to provide medical support to the

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<sup>74</sup>Raymond E. Duke, "The Training of Officers in the Medical Department," The Bulletin of the U.S. Army Medical Department 8:5 (May 1948) pp. 378-79. (Cited hereafter as Training of Officers).

<sup>75</sup>Patterson, Systematic Training, p. 231.

<sup>76</sup>Patterson, Systematic Training, p. 231.



Army, provide clinical training and refresher courses to Regular Army physicians, and at the same time, attract qualified physicians into service with the Army.

The solution to Medical Department post World War II training was to institute aggressive clinical training programs designed to raise the quality of care in the Army.<sup>77</sup> This resulted in the formation of residency programs, internships, and professional refresher courses in civilian institutions.<sup>78</sup> Priority efforts to retrain Regular Army physicians and qualify them for certification by American specialty boards caused a comprehensive review of medico-military training requirements.

The Medical Department had originally envisioned reinstating the 5-month Basic Course at the Medical Field Service School upon the conclusion of World War II, however, this was never accomplished. So many physicians had been committed to clinical training and duty assignments that they could not be spared for 5-months of basic training in military and field subjects.<sup>79</sup> In September 1949, the Medical Department shortened the Basic Course to

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<sup>77</sup>George E. Armstrong, "Educational System for Regular Army Doctors," US Armed Forces Medical Journal IV:2 (February 1953) p. 158. (Cited hereafter as Regular Army Doctors).

<sup>78</sup>Armstrong, Regular Army Doctors, pp. 158-59.

<sup>79</sup>Armstrong, Regular Army Doctors, p. 159.

4-months.<sup>80</sup> Appendix E provides an illustration of the education system implemented by the Medical Department.

In 1950, the outbreak of the Korean War necessitated further changes in Medical Department training programs. The wartime need for large numbers of physicians caused immediate contractions of residency and other clinical training programs which began after World War II.<sup>81</sup> To meet wartime needs, Major General Armstrong, the Army Surgeon General, directed a senior officer review of the physician education system.<sup>82</sup> The objective of the review was to determine the essentials medical officers needed to be taught "in both the professional and military areas."<sup>83</sup> Armstrong's board expressed a need to maintain high professional [clinical] competence and "proficiency in military aspects of medicine, including field operations."<sup>84</sup> At the recommendation of the Armstrong board, the Basic Course was reduced from 4-months to 8-weeks.<sup>85, 86</sup>

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<sup>80</sup>Duke, Training of Officers, p. 382.

<sup>81</sup>Armstrong, Regular Army Doctors, p. 159.

<sup>82</sup>Armstrong, Regular Army Doctors, p. 160.

<sup>83</sup>Armstrong, Regular Army Doctors, p. 160.

<sup>84</sup>Armstrong, Regular Army Doctors, p. 160.

<sup>85</sup>Armstrong, Regular Army Doctors, p. 160.

<sup>86</sup>Spurgeon H. Neel, "An Accounting," U.S. Armed Forces Medical Journal IV:4 (April 1953) p. 625-26. (Cited

Some literature written during the Korean War directly referred to training the Battalion Surgeon. Stout (1952) expressed his belief that

...like any other team the Army Medical Service cannot save the lives of the sick and the injured without being properly trained.<sup>87</sup>

Correlating good training to fewer casualties, Stout (1952) indicated that

The better trained the Battalion Surgeon is the more he will understand the combat patient, his medico-military problems, and the professional care he requires. He will also be better equipped to take care of himself. The harder we [the medical service] work to become well trained the less chance we have of becoming injured and the longer we are apt to live.<sup>88</sup>

In conclusion, Stout (1952) stated that the Battalion Surgeon must be trained to perform his medical-military duties. Without this training he will be unable to act confidently or inspire a sense of security in his associates or confidence from the patient.<sup>89</sup>

Assignment to front line units and the requirement for military training apparently disgruntled some physicians during the Korean war era. Replying to these apprehensions, Neel (1953) suggested that physicians needed

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hereafter as An Accounting).

<sup>87</sup>Arthur O. Stout, "Why Training?," Medical Technicians Bulletin 3:4 (July-August 1952) p. 157. (Cited hereafter as Why Training?).

<sup>88</sup>Stout, Why Training?, p. 158.

<sup>89</sup>Stout, Why Training?, p. 158.

staff and leadership training. Neel stated:

To send a medical officer into an assignment for which he is unqualified, medically and military-wise, is just as dangerous as sending an unqualified surgeon into an operating suite.<sup>70</sup>

As military medicine involved military and clinical skills, both derived from training, Neel (1953) expressed that "acumen in military medicine is not inherent in doctors...it must be developed through years of training and experience."<sup>71</sup><sup>72</sup> Military medicine during the Korean War was considered a specialty, and required that the surgeon be trained to know his patients, their problems, and the field environment in which he was expected to perform his duties. The Battalion Surgeon was expected to know how to defend himself and his patients. Any less training preparation was considered unfair to the physician and "disastrous" to the Army.<sup>73</sup>

The Snyder committee concluded its report after reviewing the Medical Department's performance in the Korean War. Recognizing that the Battalion Surgeon worked in a hazardous environment, the Snyder committee

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<sup>70</sup>Neel, An Accounting, p. 626.

<sup>71</sup>Neel, An Accounting, p. 627.

<sup>72</sup>Dan C. Ogle, "The Current Relation Between Military and Civilian Medicine," U.S. Armed Forces Medical Journal 111:7 (July 1952) p. 1119.

<sup>73</sup>Neel, An Accounting, p. 626.

concluded that the Battalion Surgeon must learn "new skills...and he must know the burden of command and the management of people."<sup>74</sup> Snyder (1955) further said:

The apparent disadvantages of discomfort, field duty...have their greater overriding advantages. The Battalion Surgeon commands higher respect in the eyes of the soldier than any other officer in the medical service.<sup>75</sup>

Regarding training, Snyder (1955) expressed a belief that the Battalion Surgeon should be knowledgeable of "supply, training, maintenance, and discipline," and that these could not be wholly delegated to a subordinate and expect that the mission would still be accomplished.<sup>76</sup> Snyder also cited leadership training as essential for the Battalion Surgeon in saving lives. Leadership, it was contended, was responsible for "an aggressive medical service organization."<sup>77</sup> Furthermore, the Snyder committee concluded that "medical officers must be impressed with the weight of their responsibilities and must be prepared to execute creditably their responsibility as leaders."<sup>78</sup> Summarizing their statements concerning the training of the Battalion Surgeon and other medical officers, Snyder (1955)

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<sup>74</sup>DA. Snyder Report, p. VI-2.

<sup>75</sup>DA. Snyder Report, p. VI-2.

<sup>76</sup>DA. Snyder Report, p. VI-14.

<sup>77</sup>DA. Snyder Report, p. VI-13.

<sup>78</sup>DA. Snyder Report, p. VI-14.

stated that the "minimum adequate period of training of newly commissioned medical officers is approximately six weeks."<sup>77</sup>

With the passing of the Korean War, literature dealing with the Battalion Surgeon gradually faded. It was not until the Vietnam War that literature again surfaced the importance of the Battalion Surgeon.

Berry (1964) indicated that surgeons needed a "spirit of belonging to the military," coupled with a belief that "military life is a philosophy for living."<sup>100</sup> A surgeon's "personal habits, attitude, and behavior must create respect in the minds of his fellow officers, from an appreciation of his poise, self-confidence, and conviction of purpose as a Military Surgeon."<sup>101</sup> As for the skills surgeons needed to be trained for, Berry (1964) suggested that the Army requires the surgeon to be

...knowledgeable in the science of military tactics, proficient in logistics and personnel management, capable of frugality and skillful in clinical medicine. He is expected to be proficient in all things medical and paramedical without arrogance or timidity...<sup>102</sup>

Cooch (1968) suggested that the Battalion Surgeon

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<sup>77</sup>DA. Snyder Report, p. VI-13.

<sup>100</sup>Berry, Surgeon-Will He Vanish?, p. 29.

<sup>101</sup>Berry, Surgeon-Will He Vanish?, p. 29.

<sup>102</sup>Berry, Surgeon-Will He Vanish?, p. 29.

"learn the ancillary skills of the line soldier and officer."<sup>103</sup> Like the practice of medicine, soldiering called for training. Cooch (1968) further indicated that physicians could "only serve them well [soldiers in the field] when we [physicians] understand what they are doing and what their problems are."<sup>104</sup>

Expressing his conclusions about training surgeons, Cooch (1968) said physicians should learn "a great deal" about tactics, logistics, evacuation, correspondence, military law, transportation, and terrain."<sup>105</sup>

Despite the urgings of the Vietnam War era literature, the Medical Department's Basic Course for physicians fell along the same path as during the previous war emergencies and was shortened.

In 1970, responding to the critical shortage of physicians throughout the Medical Department, the Army Surgeon General waived attendance at the Basic Course.<sup>106</sup> Physicians who were waived from attending the Basic Course

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<sup>103</sup>Joseph W. Cooch, "What Is Military Medicine?," Military Medicine 133:4 (April 1968) p. 293. (Cited hereafter as Military Medicine).

<sup>104</sup>Cooch, Military Medicine, p. 293.

<sup>105</sup>Cooch, Military Medicine, p. 293.

<sup>106</sup>U.S. Department of the Army, U.S. Army Medical Department, Office of the Surgeon General, Historical Unit, Annual Report: The Surgeon General, United States Army, FY 1970. (Washington: Government Printing Office, 1970). p. 85. (Cited hereafter as Annual Report FY 1970).

were provided "instructional packets" in lieu of attending the resident course.<sup>107</sup>

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<sup>107</sup>DA. Annual Report FY 1970, p. 86.



## CHAPTER 2

### SURVEY OF LITERATURE

#### PART III: SOCIOLOGY

##### Special Status

Physicians have always been a special group and enjoyed a special status within society and the Army. The basis for this appears to have derived from the "physician-patient relationship" evidenced throughout history.<sup>1</sup> For the US Army, this special status was recorded in its first set of Army Regulations, drafted by Major General von Steuben in 1780.<sup>2</sup> General von Steuben wrote:

There is nothing which gains an officer the love of his soldiers more than to care for them under the distress of sickness; it is then he has the power of exerting his humanity and making their situation as agreeable as possible. The surgeons are to remain with their regiment as well on a march as in camp, that in case of sudden accidents they may be at hand to apply the proper remedies.<sup>3</sup>

Hume (1948) reported that there were "ancient ties joining the infantryman and other soldiers of the line" to

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<sup>1</sup>Neel, An Accounting, p. 625.

<sup>2</sup>Edgar E. Hume, "Introduction to Military Medicine," The Military Surgeon, 102:1 (January 1948) p. 20. (Cited hereafter as Introduction to Military Medicine).

<sup>3</sup>Hume, Introduction to Military Medicine, p. 20.

the physician.<sup>4</sup> From the combat soldier's point of view, Hume (1948) stated that the "morale value of that tie cannot be overestimated."<sup>5</sup>

Over a century and a half later, literature recorded the special status of physicians from a different viewpoint. By the end of the Korean war, the physician was still special, but with the following differences:

1. Physicians were deferred from the draft to complete their education.
2. Physicians received special educational financing from the Government.
3. Physicians were drafted as a group [profession] when other were not.
4. Physicians received special trust and admiration from those around them.<sup>6</sup>

The Battalion Surgeon was considered "an important fellow" whose significance and working at the "grass roots of war" should not be overlooked.<sup>7</sup> The special status and considerations to be given physicians was reported by Cass (1978). On page one of his study, Cass (1978) said:

The Medical Corps officer, the Army physician, is the team leader, the quarterback. The role of the physician as leader is accepted by other physicians, by other health care professional, by line commanders, and

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<sup>4</sup>Hume, Introduction to Military Medicine, p. 21.

<sup>5</sup>Hume, Introduction to Military Medicine, pp. 21-22.

<sup>6</sup>Neel, An Accounting, p. 625.

<sup>7</sup>Edward D. Churchill, Surgeon to Soldiers (Philadelphia, PA: J.B. Lippincott Co., 1972), p. 22.

by patients.<sup>6</sup>

Taking the position that physicians were the only group from all health care professionals who should fill key command and staff position, Cass (1978) supported his thesis with documentation from the NATO Allies, Israel, and the USSR. Cass (1978) summarized the comments from the Royal Danish Medical Forces, the Federal Republic of Germany Medical Forces, the Royal Army Medical Corps, and the Italian, Turkish, Israeli and USSR medical forces as follows:

1. Line commanders do not rely on medical operations developed by non-physicians.
2. Physicians must command medical units.
3. Physicians cannot accept non-physicians as their boss or commander.
4. Physicians must know the Army as well as their profession.<sup>7</sup>

Accordingly, the "moral, ethical and legal requirement" of physicians to deliver health care mitigated against any person other than a physician being in charge.<sup>10</sup>

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<sup>6</sup>Kenneth A. Cass, "The Requirement For Medical Corps Officers (Physicians) To Be Medical Facility Commanders and Major Medical Staff Officers In NATO and HSC," (U.S. Army War College, 1978), p. 1. (Cited hereafter as Medical Corps Officers).

<sup>7</sup>Cass, Medical Corps Officers, pp. 20-36.

<sup>10</sup>Cass, Medical Corps Officers, p. 10.

Physicians have retained their special status because they have been the primary health care policy and decision makers. Even in the civilian world, physicians dominate the health care environment. Drucker (1978) indicated that "the medicos (physicians) can force out any administrator."<sup>11</sup> A special status accorded to physicians is also found in Army Regulation 40-1 (Composition, Mission, and Function of the Army Medical Department-1983) which indicates:

health facilities will be commanded by an MC officer qualified to assume command under AR 600-20. The MC officer will command, even though an officer of another branch may be the senior regularly assigned officer present.<sup>12</sup>

Despite the past historical leadership provided by the physician to the Medical Department and its health care team, physicians gradually gave up many of their responsibilities to "allied health professionals" in the early 1970's.<sup>13</sup> In the case of the Battalion Surgeon, these responsibilities were turned over to the Physician's Assistant and to the Medical Service Corps officer.

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<sup>11</sup>Peter F. Drucker, "An Interview With Peter F. Drucker On The Dynamics of Health Care Administration," Review Federation of American Hospitals (February 1978) p. 14.

<sup>12</sup>DA. AR 40-1, p. 9-9.

<sup>13</sup>Robert L. Doctor, "An Evolution of the Formal Organization Structure of the Army's Allied Health Professional," (U.S. Army Command and General Staff College, 1973), p. 3. (Cited hereafter as Allied Health Professionals).

### Recruitment and Retention

Since World War I, and particularly the late 1960's to the present, the most difficult personnel management problem in the Army Medical Department was the procurement and retention of physicians.<sup>14,15</sup> The literature abounded with topics dealing with this subject. A study of the Battalion Surgeon must include an understanding of the history and motivations physicians have displayed for service, not only as Battalion Surgeons, but as officers in general.

The heavy consumption of physicians during World War II emphasized the notion that physicians were a rare commodity, for which there was no acceptable substitute.<sup>16</sup> This was especially felt considering the United States had nearly exhausted its manpower base by late 1944.<sup>17</sup> Besides the national concern for the number of physicians available, physicians themselves began to express popular concerns for how they were utilized.

Conn (1942) recorded a notion among physicians of the 1940's, eager for specialization training but assigned

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<sup>14</sup>Tobey, Medical Department of the Army, p. 84.

<sup>15</sup>Jon N. Harris, "Some Considerations in Adjusting the Compensation Package for Army Medical Corps Officers," (U.S. Army War College, 1975), p. 2. (Cited hereafter as Compensation Package).

<sup>16</sup>War Department. AGF Battle Casualties, p. 1.

<sup>17</sup>War Department. AGF Battle Casualties, p. 1.

as Battalion Surgeons, that they would "atrophy of previous knowledge and experience."<sup>18</sup> The feeling abounded that although a physician's medical opinion and technical knowledge were valuable, trained technicians could diagnose and treat the common forms of casualties.

Upon the conclusion of World War II, Stelter (1955) highlighted the conclusions of a 1946 survey of 26,000 medical officers who had served the war effort.<sup>19,20</sup> Physicians surveyed indicated that they spent only 50% of their time doing clinical duties, and 30% of their time doing non-clinical duties.<sup>21</sup> During periods of combat activity, physicians indicated that they needed only 80% of the workday to accomplish their duties.<sup>22</sup> Physicians were provided even more relief towards the end of the war once MAC officers were assigned as Assistant Battalion Surgeons.<sup>23</sup> This was only one example of the "economies in the use of medical personnel" undertaken by

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<sup>18</sup>Conn, Battalion Medical Officer, p. 119.

<sup>19</sup>Grant D. Stelter, "Use of Medical Officers As Battalion Surgeons," (U.S. Army Medical Field Service School, 1955), pp. 1-2. (Cited hereafter as Battalion Surgeons).

<sup>20</sup>F.G. Dickinson, "Analysis of the Replies to the Post War Questionnaire," American Medical Association Bulletin 58 (1947) pp. 1-28.

<sup>21</sup>Stelter, Battalion Surgeons, p. 2.

<sup>22</sup>Stelter, Battalion Surgeons, p. 2.

<sup>23</sup>Neel, An Accounting, p. 625.

the Medical Department.<sup>24</sup> Using MSC officers as health care extenders to replace the Battalion Surgeon in the medical platoons was an issue often discussed and studied after World War II.<sup>25</sup>

The Snyder committee felt that the US Army had overeconomized the use of valuable and trained physicians after World War II and into the Korean war.

Although peacetime care of patients had occupied the Medical Department's concern after World War II and the Korean War, Snyder (1955) felt it was a "secondary" mission.<sup>26</sup> The "big business" of peacetime care had become the Army's primary orientation and focus for future planning.<sup>27</sup> Snyder's committee concluded that until the Army became "an instrument of social reform or a mechanism of sustaining the national economy," that the Medical Department should devote its primary endeavors to providing battlefield medical support.<sup>28</sup>

Difficulty with recruiting volunteer physicians after the demobilization of World War II and the Korean War

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<sup>24</sup>Paul I. Robinson, "About the Medical Department," The Bulletin of the U.S. Army Medical Department VII:9 (September 1948), p. 671.

<sup>25</sup>Stelter, Battalion Surgeons, n.p.

<sup>26</sup>DA. Snyder Report, p. VII-1.

<sup>27</sup>DA. Snyder Report, p. VII-1.

<sup>28</sup>DA. Snyder Report, pp. VII-1, VII-2.

created the "doctor draft."<sup>29</sup> Berry (1964) cited the numerous reasons for the high numbers of resignations from physicians who had completed their draft obligations of service:

- marriage and family with desire to settle in and be a part of a fixed community.
- small and isolated stations in many parts of the world.
- unattractive tours of duty, less professionally rewarding with inability to attend larger medical meetings.
- too frequent movement between stations.
- wife's lack of interest in a military life.
- desire for greater independence in the practice of medicine.
- higher remuneration in civilian life.<sup>30</sup>

Boyson's survey of Regular Army Medical Corps physicians who had resigned and retired from service was one of the first of its kind found in the literature. Boyson (1967) attempted to determine why the Army Medical Department was experiencing such high loss rates. The study, "Why Doctors Get Out," reflected that the "prospect of command or administration" was a common factor among the groups of physicians surveyed.<sup>31</sup> This was second only to

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<sup>29</sup>Berry, Status of Medical Officer, p. 1125.

<sup>30</sup>Berry, Status of Medical Officer, p. 1129.

<sup>31</sup>William A. Boyson, "Why Doctors Get Out," (U.S. Army War College, 1967), pp. 11-12. (Cited hereafter as Why Doctors Get Out).



"inadequate pay" as a reason physicians were leaving the Army.<sup>32</sup> The most "vehement" replies were to the question related to command and administration. Physicians generally expressed the opinion that they had "no training or inclination for administration."<sup>33</sup> Maintaining clinical skills was an expressed concern, most physicians feeling their "professional competence would seriously deteriorate if they left full-time clinical practice."<sup>34</sup>

Many physicians also reported that they did not feel "a real sense of belonging to the Army."<sup>35</sup> This was perhaps because they felt that line officers had a "low regard for medical officers."<sup>36</sup>

Boyson (1967) concluded his study by finding most physicians unwilling to "compromise...hard earned [clinical] competence by diluting their time with command and administration."<sup>37</sup> Although Boyson (1967) broached the idea of giving all "command and administrative assignments to Medical Service Corps officers," he was quick to point out that physicians would "balk at direction and command by

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<sup>32</sup>Boyson, Why Doctors Get Out, p. 20.

<sup>33</sup>Boyson, Why Doctors Get Out, p. 20.

<sup>34</sup>Boyson, Why Doctors Get Out, p. 20.

<sup>35</sup>Boyson, Why Doctors Get Out, p. 25.

<sup>36</sup>Boyson, Why Doctors Get Out, p. 26.

<sup>37</sup>Boyson, Why Doctors Get Out, p. 21.

anyone except another physician."<sup>38</sup>

Another thesis conducted in 1967 presented findings similar to Boyson's. Baker (1967) conducted a study of 2,000 active duty Medical Corps officers to determine their views on problems relevant to physician retention in the Army. Of the 12 problems identified, two areas were particularly relevant to this study:

1. Medical officers are apprehensive of administrative duty.
2. Due to lack of sufficient prior military training-orientation, the majority of medical officers are not acquainted with the problems of the individual soldier and/or the line officer.<sup>39</sup>

Both findings matched Boyson's (1967) report, citing physician apprehension over "administration."<sup>40</sup>

One year after Boyson (1967) and Baker (1967) completed their studies, Winkler (1968) completed yet another investigation into the problem of physician retention. Winkler's thesis sought to study the various factors involved in retaining physicians in military service. Winkler (1968) surveyed 1,000 Regular Army physicians, many of whom had already been surveyed by

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<sup>38</sup>Boyson, Why Doctors Get Out, pp. 21-22.

<sup>39</sup>Floyd W. Baker, "Problems in Retention of US Army Medical Corps Officers," (Industrial College of the Armed Forces, 1967), pp. 195-96.

<sup>40</sup>Floyd W. Baker, "Why Do Doctors Stay in the Army," Military Medicine 134:3 (March 1969) p. 197.

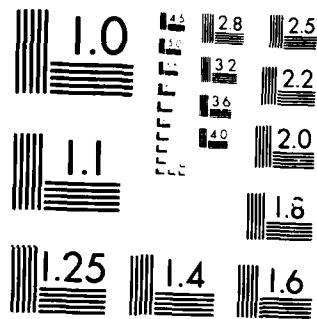
THE BATTALION SURGEON: A BACKGROUND STUDY AND ANALYSIS  
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Baker (1967).<sup>41</sup> Although Winkler (1968) found that the "threat of a possible command or administrative assignment" was a major cause for physicians leaving the service, he provided several new conclusions not reported by Boyson (1967) or Baker (1967).<sup>42</sup>

1. Physician retention improved with each succeeding level of the Military School System attended. This began with the AMEDD Basic Course.<sup>43</sup>

2. Physicians who had served with troops, or in command and field-administrative medicine showed higher retention probability.<sup>44</sup>

In his final conclusions, Winkler (1968) asserted the following:

the most potent forces in promoting retention of medical officers are experiences which increase the identification of the physician with the Army and its goals.<sup>45</sup>

It should be interesting to note that Winkler (1968), then a Major at the Command and General Staff College, became a Major General and the Commandant of the Academy of Health Sciences. By 1984, sixteen years later,

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<sup>41</sup>William P. Winkler, "A Study To Evaluate Factors Involved In Retention of Medical Officers In The Military Service," (U.S. Army Command and General Staff College, 1968), pp. 193-94. (Cited hereafter as Retention of Medical Officers).

<sup>42</sup>Winkler, Retention of Medical Officers, pp. 193-94

<sup>43</sup>Winkler, Retention of Medical Officers, pp. 49-54.

<sup>44</sup>Winkler, Retention of Medical Officers, pp. 63-70.

<sup>45</sup>Winkler, Retention of Medical Officers, p. 194.

General Winkler had largely directed the plan and decision to reintroduce the Battalion Surgeon. However, none of Winkler's recommendations had been implemented. Among those relevant to this study:

1. The AMEDS Basic Course should be attended by all medical officers as soon as practicable after entry on active duty.

2. It should be established policy in selecting physicians for residency training in military hospitals to give preference to medical officers who have served with a troop unit or have completed Airborne, Special Forces or Ranger training.

3. All physicians accepted for residency training in a military hospital should have a minimum of six months service with a troop unit prior to beginning the residency.<sup>46</sup>

As long as the Army had a "doctor draft," it was able to complete its medical support mission. With the end of the physician draft on 1 July 1973 however, the Army had to consider a variety of methods to satisfy its mission with now scarce resources. Since the end of World War II, the Army developed a number of programs to strengthen physician retention in Army service. This included the following:

Special entry grades

Special promotion system

Educational financial assistance

Constructive credit for computing pay, promotion and grades

Special pay including variable incentive pay, continuation pay and reenlistment bonuses <sup>47</sup>

The Army also used "physician extender" programs

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<sup>46</sup>Winkler, Retention of Medical Officers, pp. 195-96.

<sup>47</sup>Harris, Compensation Package, pp. 2-5.

and administrative personnel to allow physicians to spend more time utilizing his clinical skills.<sup>48</sup>

These combinations of laws, policies and programs were designed to basically increase physician compensation in return for higher recruitment and retention. Some of the programs however, such as the special promotion system, had a negative impact on the Army officer corps. The rank issue became a major problem in the early 1970's when Congress noted the "grade creep" within the Medical Corps.<sup>49</sup> During a period of the mid 1970's, Medical Corps officers were being promoted at the expense of the remainder of the Army officer force.<sup>50</sup> But compensations failed to draw or retain a sufficient number of physicians to the Army.<sup>51</sup>

A study published in 1976 showed that high salaries and other compensations were insufficient to draw physicians to the military.<sup>52</sup> The "military atmosphere"

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<sup>48</sup>Harris, Compensation Package, p. 3.

<sup>49</sup>Harris, Compensation Package, p. 16.

<sup>50</sup>Harris, Compensation Package, p. 17.

<sup>51</sup>U.S. Department of Defense, Manpower and Reserve Affairs, Special Pays: Special Compensation for Physicians, Dentists, and Veterinarians, and Continuation Pay for Physicians. (Report of the 1971 Quadrennial Review of Military Compensation). (Washington, D.C., 1971. (AD 892 408).) p. 1.9.

<sup>52</sup>U.S. Department of the Army, Defense Supply Service, Study of the Recruitment of Medical Professionals

was the singlemost reason cited for physicians leaving the Army.<sup>83</sup> Other negatives associated with military practice by physicians were:

- repeated relocations
- dislike for military discipline
- objection to the concept of rank
- dislike for the wear of a uniform
- concern over clinical practice and medicine <sup>84</sup>

Many of the legislative compensation moves appeared to have been ineffective. Rank upon entry of active duty was rated the least important for conditions to a military practice--while the simple ability to negotiate the initial assignment rated highest.<sup>85</sup> Military discipline however, was viewed as the "most important objection to a military practice."<sup>86</sup>

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For Military Service by the research staff of Opinion Research Corporation. (DOD Contract MDA 90375 C 0221; microfiche). (Princeton, N.J., 1976. (AD A 056 989).) pp. iii, iv. (Cited hereafter as Recruitment of Medical Professionals).

<sup>83</sup>DA. Recruitment of Medical Professionals, p. II-6.

<sup>84</sup>DA. Recruitment of Medical Professionals, p. II-15.

<sup>85</sup>DA. Recruitment of Medical Professionals, p. II-25.

<sup>86</sup>DA. Recruitment of Medical Professionals, p. III-16.



### Summary

The recruitment and retention of Army physicians has been a persistent historical problem often tied to the influence and controls imposed by the "civilian medical economy."<sup>87</sup> It has only been alleviated in the past by a "doctor draft." In the absence of a doctor draft since 1973, the Medical Department relied on a variety of legislative and physician extender programs to compensate physician pay, rank, promotions and clinical practice. One action taken along this line was the elimination of the Battalion Surgeon's position.

The AMEDD initially profited from the removal of the Battalion Surgeon. This could be measured in terms of physician retention, status in terms of pay, benefits and clinical production increases. But for the sake of these economies, the Medical Department lost its command presence in the line maneuver unit, allowing other systems to replace it. Physicians became models of an "entrepreneurial bureaucracy" which Gariel (1981) states, stresses the "ethics of self-interest."<sup>88</sup> Physicians were

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<sup>87</sup>Ogle, Military and Civilian Medicine, p. 1119.

<sup>88</sup>Richard A. Gabriel, "Modernism vs Pre-Modernism: The Need To Rethink The Basis of Military Organizational Forms," as found in Chapter 4, James Brown and Michael Collins, Military Ethics and Professionalism: A Collection of Essays (Washington, D.C.: National Defense University Press, 1981), p. 61.

motivated to service and retention by material requirements, evidenced by the numerous legislative actions passed to provide greater physician compensation. The retention studies conducted by Berry (1964), Boyson (1967), Baker (1967), Winkler (1968), and Opinion Research (1976) all provided examples of physician dissatisfaction with the traditional values and environment of the Army.

## CHAPTER 3

### FINDINGS

#### Introduction

Chapter 2, Survey of Literature, reported the literature findings on the Battalion Surgeon from the end of World War I to the present time. This historical review provided a fundamental insight into the position and personality of the Battalion Surgeon. The professional development and training of the Battalion Surgeon, and his special status and attitude within the Army was also reported on.

Chapter 3, Findings, will attempt to consolidate the literature findings, and then describe their significance relative to the current plan to reintroduce the Battalion Surgeon.

#### Position Stability

A study of the Battalion Surgeon must include an identification and explanation of the reasons the position was disestablished. This background is necessary if an insight is to be gained into the current reestablishment of the position. It should also discuss the impact, observed or perceived, and the interim developments caused by the

momentous decision to eliminate the Battalion Surgeon.

As shown clearly in the literature surveyed by this study, physician shortages have always influenced assignments, education, training, career planning, and other personnel actions, not only of the Medical Corps, but the AMEDD itself. Relevant to this thesis, the Army Medical Department focus on the problem dealing with the acute shortage of physicians resulted in the elimination of the Battalion Surgeon in early 1970. Removing the Battalion Surgeon was an attempt to produce more health care output with less physician resources. As suggested by Marston (1969), substituting the Battalion Surgeon with a non-physician was like a process of

...borrowing from Peter to pay Paul, or of playing a game of musical chairs in which one resource [physicians] has been added each time the music stops. [This process] can only succeed in disrupting the impressive health organization and mechanisms that have been built up so laboriously over generations.<sup>1</sup>

The Vietnam war produced helicopter evacuation, sophisticated medical facilities, and modern medical education as the official reasons for the obsolescence of the Battalion Surgeon. Yet it is clear that Physician's Assistants and Medical Service Corps officers replaced the Battalion Surgeon to alleviate the shortage of physicians.

Although the Medical Department has always

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<sup>1</sup>Robert Q. Marston, "The Several Paths to Quality," Military Medicine 134:3 (March 1969) p. 168.

been historically concerned over the shortage of qualified physicians, the rapid mobilization and expansion of forces during World War II initiated the gradual erosion of physician preeminence in medical field units still evidenced today. It was during World War II that Medical Administrative Corps officers first began to assume many of the non-medical duties traditionally held by physicians. Bowing to pressure from the Army General Staff and the Services of Supply to reduce the number of physicians in tactical medical units, the Army Medical Department began to allow for non-physician substitutions.<sup>2</sup> Once introduced, these physician extenders performed very well as substitutes for physicians. Over the years, these non-physician positions have been developed and improved upon with professional development strategies of their own. Gradually, the positions and the officers filling them, have overtaken the physician's role, experience, and training at the maneuver battalion level and higher.

Neel (1953) was among the first authors to warn the Army Medical Department of an overextension of its non-physician substitutions. Neel (1953) prophesized the "loss of control by physicians" and their being "relegated

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<sup>2</sup>U.S. Department of the Army, U.S. Army Medical Department, Office of the Surgeon General, Organization and Administration in World War II by John B. Coates. (Washington, D.C.: Government Printing Office, 1963. (Medical Department of the U.S. Army in World War II series).) p. 114.

to purely technical duties."<sup>3</sup> The 1984 decision to reestablish the Battalion Surgeon directly acted to regain physician control and experience in field medical units. It also expanded the range of physician duties beyond the purely clinical realm.

As important as the reasons why the Battalion Surgeon was replaced is the impact it had upon the Medical Department. Fundamentally, the training base for the development of Medical Corps officers was eliminated. Physicians lost the opportunity, as Battalion Surgeons, to experience and develop leadership and medical support skills from the platoon level up. A half generation of physicians have thus been denied the experience of "seeing" and "living" front line medical support. One can only speculate where this generation of physicians will draw their experience from once they ascend to leadership roles in the Medical Department. Military professionalism suffered heavily as a result of the elimination of the Battalion Surgeon and the virtual removal of all physicians from medical field organizations.

#### Need

In spite of the expedient concessions and trade-offs made to alleviate physician shortages resulting

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<sup>3</sup>Spurgeon H. Neel, "An Accounting," U.S. Armed Forces Medical Journal 4:4 (April, 1953) p. 627.

in the loss of the Battalion Surgeon, the literature consistently accentuated the need for front line physician care. Rankin (1945) indicated from World War II experience that

...medical care in advanced battle zones was based upon the principle that the sooner a wounded man receives adequate first aid and subsequent definitive surgery, the more successful are the results.<sup>4</sup>

The Korean war revealed findings similar to World War II. The Snyder Committee maintained that the Battalion Surgeon was the key to maintaining the effective strength of the line battalion.<sup>5</sup> The Battalion Surgeon was described as

...the single individual who can salvage or dissipate the strength of a Battalion thru either good battlefield treatment and care or through subsidized straggling under the disguise of the apparently cautious, meticulous and sympathetic practice of medicine.<sup>6</sup>

Snyder (1955) further concluded that any improvement in the care of battle casualties rested in the improvement of medical support "forward of the hospital," and in particular the maneuver battalion area where "the most significant improvement in mortality can be achieved."<sup>7</sup>

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<sup>4</sup>Rankin, American Surgeon, p. 176.

<sup>5</sup>DA. Snyder Report, p. VI-1.

<sup>6</sup>DA. Snyder Report, p. VI-1.

<sup>7</sup>DA. Snyder Report, p. I-1.

<sup>8</sup>DA. Snyder Report, p. III-2.

MG Winkler, in his proposals for a revamped medical support system, has not ignored the value of the Battalion Surgeon in maintaining the fighting "foxhole" strength of units in combat.

Snyder (1955) and Stelter (1955) both found reason to maintain and strengthen the Battalion Surgeon's position. Citing reasons in 1955 similar to those expressed by the Medical System Program Review in 1984, the Battalion Surgeon was found to be a necessary position for some of the following reasons:

- Prevention of unnecessary casualty evacuation
- Contribution to the morale of combat personnel
- Professional judgement of priorities and optimal time for emergency evacuation of casualties
- Expert emergency treatment of casualties
- Supervision of the use of potent medications\*

From his experience in the Vietnam War as a Battalion Surgeon, Mosebar (1968) provided justification for keeping the Battalion Surgeon just two years before the position was eliminated. He said:

Treatment and evacuation require the application of professional [physician] medical judgement at the forward treatment element and at all subsequent treatment facilities.<sup>10</sup>

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\*Grant D. Stelter, "Use of Medical Officers as Battalion Surgeons," (Student Paper, Medical Field Service School, 1955), Annex B, pp. 1-4.

<sup>10</sup>Robert H. Mosebar, "The Role of the Battalion Surgeon in Vietnam," (U.S. Army War College, 1968), p. 12.



The Israeli combat experience and medical lessons of war since 1968 provided further historical reasons for maintaining the Battalion Surgeon. Israeli medical care readily emphasized the "medicalization of the lowest combat echelons."<sup>11</sup> The Army Medical Department at the time took note, but ignored the Israeli lessons because of acute physician shortages. Major General Winkler and his staff have apparently reaccessed the Israeli experiences, for the 1984 Medical Systems Program Review initiatives closely incorporated the Israeli principles of front line medical support. Nagan and Cordova (1982) provided some examples of these Israeli principles:

The policy of caring for the wounded on the battlefield by the Medical Corps has been based...on the principle that fast evacuation is not the most urgent need but that immediate care for the soldier and his preparation for evacuation must be done effectively and with the utmost attention.<sup>12</sup>

[The provision for] the constant supervision and accompaniment of every moderately and more seriously wounded by a medic or a doctor, from the moment the treatment begins until he arrives at a hospital.<sup>13</sup>

This immediate, on the spot medical attention and

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<sup>11</sup>DA. Yom Kippur War, p. 9.

<sup>12</sup>U.S. Department of the Army, U.S. Army Medical Intelligence and Information Agency, Medical Care and Evacuation of Wounded Soldiers: Policy and Organization During the Yom Kippur War by L. Nagan and M. Cordova. (USAMIIA-HT-002-82; microfiche). (Fort Detrick, MD.: USAMIIA, 1982. (AD B063 991).) p. 3. (Cited hereafter as Medical Care).

<sup>13</sup>DA. Medical Care, p. 4.

care was provided by physicians practicing medicine far forward on the battlefield, principally in the maneuver battalion area. This literature further reported that in some circumstances the Israeli front line company had one physician and corpsman assigned. This truly emphasized the Israeli attempt to "medicalize" at the lowest tactical level possible. Maneuver battalions had one physician whose duties included:

- Coordinating medical support
- Controlling medical collection resources
- Preparing casualties for evacuation
- Performing the first surgical resuscitation action necessary<sup>14</sup>

It should be noted that the Israeli physician operated at the Battalion Aid Station without the comparable assistance of a US Army Physician's Assistant or a Medical Service Corps officer.

Beyond the findings suggesting a need for the Battalion Surgeon, this particular literature emphasized the morale value of the Battalion Surgeon which has been largely underestimated since World War II.<sup>15</sup> During the Korean war, the Army Surgeon General discovered from hundreds of personal interviews with combat soldiers that the medical care they received was a great morale

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<sup>14</sup>DA. Yom Kippur War, p. 9.

<sup>15</sup>War Department. Human Casualties, p. 32.

factor. The Army Surgeon General reported:

They go into battle with more confidence, knowing that if anything does happen to them, they will get the very best of care.<sup>16</sup>

Stelter (1955) reaffirmed the positive morale aspect provided by a "Battalion Doc."<sup>17</sup> Relating the experience of a veteran Battalion Surgeon, Stelter (1955) provided the following insight:

While little more than first aid can be rendered at a battalion aid station, there is that inherent right of the combat soldier to know that he has a Medical Corps officer looking after his interest. The value of this cannot be measured in the capability of any other individual to apply splints or give blood transfusions. It is the "something else" that cannot--and should not--be measured in purely mechanical terms.<sup>18</sup>

During the Vietnam war, rapid helicopter evacuation and close sophisticated medical facilities replaced or supplanted the morale aspect the underutilized Battalion Surgeon may have been able to provide.

#### Duties and Responsibilities

It has been established that the Battalion Surgeon's duties involve command, staff, and clinical responsibilities. As a commander of the medical platoon,

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<sup>16</sup>n.a. "Army Surgeon General Commends Medics," Medical Technicians Bulletin 3:5 (September-October 1952) p. 212.

<sup>17</sup>Stelter, Battalion Surgeons, p. 2.

<sup>18</sup>Stelter, Battalion Surgeons, Annex B, p. 2.

the physician must be capable of organizing, training, leading, supervising, and maintaining his unit personnel and equipment. With regards to his responsibilities for the medical platoon personnel, the Battalion Surgeon should

...know his men by sight and name, and be interested in their individual peculiarities. And this should be a real interest - the soldier is quick to detect perfunctory, patronizing forms of apparent interest.<sup>19</sup>

To fulfill his other responsibilities, the Battalion Surgeon must understand "logistics, selection of camp, the chain of evacuation, the need for cooperation with other units...and medical intelligence."<sup>20</sup> In his role as a staff officer, the Battalion Surgeon's duties are both advisory and technical in the supervision of all subordinate medical systems and personnel.<sup>21</sup> The Battalion Surgeon provides information to the Battalion Commander on the physical and mental health aspect of both individuals and units.<sup>22</sup> Therefore, the Battalion Surgeon must "learn to be a good administrator."<sup>23</sup>

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<sup>19</sup>John S. Billings, "The Military Medical Officer at the Opening of the Twentieth Century," Military Medicine, 129:9 (September, 1964), p. 816.

<sup>20</sup>Berry, Status of Medical Officer, p. 1130.

<sup>21</sup>DA. AR 40-1, p. 2.

<sup>22</sup>Ralph L. Christy, "The Military Medical Officer in Support of Command and the Military Mission," Military Medicine, 129:3 (March, 1964), p. 243.

<sup>23</sup>Cooch, Military Medicine, p. 293.

To accomplish all these duties, the literature clearly emphasized that the Battalion Surgeon must be prepared to assess and personally survive the disease, the environment, the fatigue, and the psychological aspects of the military.<sup>24</sup>

Finally, as a clinician, the Battalion Surgeon must most importantly be able to advise "as to preventive medicine, sanitation, illness in the area, and safety measures" to be taken within a battalion area.<sup>25</sup>

Concerning the extent of his clinical treatment duties, a veteran surgeon suggested:

...until he becomes battle-wise, he will be tempted to go in for more extensive treatment than there is time for. All he can do so far forward is to clear the wound of clothing, mud and missiles and apply a dry dressing, supported and kept in place by an even, firm bandage. There is no time to do anything else.<sup>26</sup>

### Training

Until the establishment of the first system of medical training in 1891, physicians learned to perform their medical and military duties through actual experience with troops. This meant that physicians were trained by

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<sup>24</sup>Robert Bernstein, "Getting to the Fight: A Review of Physical and Emotional Problems Encountered in Moving Troops Into Combat," (U.S. Army War College, 1964), p. 7.

<sup>25</sup>Berry, Status of Medical Officer, p. 1130.

<sup>26</sup>Anthony Cotterell, R.A.M.C. (New York: Hutchinson & Co., 1944), p. 23.

the trial and error system of learning by mistakes. As recorded in the the literature reviewed for this thesis, untrained physicians became embarrassments to their command because of their lack of professional military knowledge. Line officers have historically developed intolerant attitudes towards untrained and unmotivated physicians. The Army Medical Department, at least in its history of writings, has generally recognized the value of using military training to transform physicians into professional Army Medical Corps officers. Regretably, this recognition has often been purely rhetorical. The actual training has oftentimes failed to occur to a full degree of time or intensity.

History has shown that the failure of physicians to be trained and assigned to units well before their deployment to combat zones resulted in excessive casualties because of this insufficient preparation. Trial and error adjustments during actual combat operations were commonplace. The conclusive findings of the literature was that a unit cannot be considered capable of performing its primary mission unless the unit has its authorized personnel and equipment, and has been organized, trained, and evaluated by its wartime leader, the Battalion Surgeon.

Training physicians to be qualified front line surgeons has never been easy, especially during active conflicts. A shortage of time and a lack of proper emphasis

has always mitigated against the Army Medical Department in properly training physicians to perform both tactical and clinical skills. When lulls between major conflicts have occurred, the emphasis on wartime military medical training and preparation has always been replaced by a peacetime emphasis on clinical training programs.

It is not surprising that these lessons from history have not been learned very well. The Handbook on Emergency War Surgery indicated the following:

Success in military medicine...has been achieved despite the fact that, over the ages, many--sometimes most--of the lessons of the past, all learned by hard experience, ordinarily lie fallow between conflicts. Almost invariably, they have had to be rediscovered, relearned by additional hard experience, and expanded and adapted by succeeding medical generations as new emergencies have arisen.<sup>27</sup>

A tri-service initiative in forming the Combat Casualty Care Course in 1980 had the purpose of preparing "military medical officers to function on an integrated battlefield during a high intensity conflict at forward points in the casualty care system."<sup>28</sup> As a high visibility and expertly conducted course within the Department of Defense, the Combat Casualty Care Course is

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<sup>27</sup>U.S. Department of Defense, Emergency War Surgery. (Washington, D.C.: Government Printing Office, 1975). pp. 1-2.

<sup>28</sup>Charles R. Terry, "Medical Wartime Training Programs For Physicians of the Armed Forces: 1979-1981," (U.S. Air Force War College, 1981), pp. 23-4. (Cited hereafter as Wartime Training).

of short duration, possesses a clinical scope, and draws students from the three military services.

A popular notion has been expressed that physicians could be "trained and prepared" to assume platoon and higher level duties by attending the Combat Casualty Care Course in lieu of an expanded Officer Basic Course with a greater emphasis on platoon level tasks, and a greater investment in time. This is merely an expedient and historically unsound idea. The Combat Casualty Care Course does not make any pretense--in its course description or in practice, from my own careful observations-- of graduating an Army medical platoon leader, or a Battalion Surgeon prepared and trained to operate throughout the wide spectrum of conflict, especially peacetime garrison duty. Although the course helps physicians in the preparation of their professional (clinical) wartime duties, the Combat Casualty Care Course was not developed systematically to train Battalion Surgeons to function as medical platoon leaders. The AMEDD Officer Basic Course, by Army Regulation, is supposed to accomplish this function.

As part of the Army School System, the AMEDD Officer Basic Course is designed to qualify individuals for duty positions to which they are assigned.<sup>27</sup> This is accomplished by executing a carefully devised program of

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<sup>27</sup>DA. AR 351-1, p. 1-1.



instruction, based on an appropriate analysis of skills to be competently performed by the individual being trained.<sup>30</sup> The "basic branch orientation" currently provided to newly commissioned Medical Corps officers who do happen to attend the Officer Basic Course, is broad in scope and can by no means be considered to qualify physicians for any specific duty position, much less as a Battalion Surgeon.<sup>31</sup> Herein lies the need to study the training a Battalion Surgeon needs to in order to accomplish his duties and responsibilities.

#### Professionalism

The literature findings continuously stressed the importance of the Battalion Surgeon as a key individual in both the treatment and evacuation system on the battlefield and at the command and staff level of the combat battalion.<sup>32</sup>

Army medical service, in peace and war, involves much more than professional attendance with the organization, administration, supply, training, sanitation, and field tactics of medical troops, as well as evacuation, professional care, and proper

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<sup>30</sup>DA. AR 351-1, p. 1-1.

<sup>31</sup>U.S. Department of the Army, Formal Schools Catalogue (Pamphlet 351-4). (Washington: Government Printing Office, 1984). p. 1327.

<sup>32</sup>DA. Snyder Report, p. VI-1.

disposition of military patients...<sup>33</sup>

The Battalion Surgeon, it has already been pointed out, is unique in that he alone bears all the above responsibilities. Yet history has also demonstrated the difficulty many physicians have had "accepting duties which do not fully occupy their professional [clinical] time."<sup>34</sup> The Battalion Surgeon is one such duty position traditionally avoided by physicians. There is not any indication in the literature that this physician's attitude has improved or that the Battalion Surgeon's position is more acceptable now than it has been in the past.

Churchill (1972) reported from his World War II experience that Army officers viewed physicians as "headstrong and undisciplined...who had no knowledge or respect for military orthodoxy."<sup>35</sup> This closely approximates my own observations, with few exceptions, from my eleven years of service. Brown (1983) also documented the "non-military tastes and temperaments" of physicians during

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<sup>33</sup>Joseph R. Darnell, "A General Perspective of the U.S. Army Medical Service," The Army Medical Bulletin (April 1942) p. 160.

<sup>34</sup>Ralph L. Christy, "The Military Medical Officer in Support of Command and the Military Mission," Military Medicine 129:3 (March 1964) p. 243. (Cited hereafter as Military Medical Officer).

<sup>35</sup>Churchill, Surgeon to Soldiers, p. 33.

World War II.<sup>34</sup> As Brown (1983) related, this situation caused the weight of training and organization of medical units to fall upon medical noncommissioned officers.<sup>37</sup>

In probable awareness of these negative physician sentiments, Graham (1943) warned Battalion Surgeons to

slough off the attitudes of the lone wolf practitioner, the commanding general, and the medico

incarnate who can do and talk nothing outside his chosen study.<sup>38</sup>

Recommending against separating physicians into two artificial groups, clinicians and field men, the Snyder Committee expressed the following sentiments:

No medical staff officer is a good medical staff officer unless he is basically a good clinician. And no clinician can do his job to the best interests of the military service unless he is wholly familiar with the military implications of his clinical functions.<sup>39</sup>

The historical lessons have shown that Battalion Surgeons are integral parts of their units. As such, they "must be subject to the same discipline, hazards and

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<sup>34</sup>John S. Brown, "Draftee Division: A Study of the 88th Infantry, First Selective Service Division Into World War II," (Master's Thesis, University of Michigan, 1983), pp. 122-23. (Cited hereafter as Draftee Division).

<sup>37</sup>Brown, Draftee Division, p. 123.

<sup>38</sup>Wallace H. Graham, "Notes to Officers of Hospital Units and Battalion Surgeons," The Military Surgeon (May, 1943) p. 574.

<sup>39</sup>DA. Snyder Report, pp. Vi-15,16.

operational requirements" as their units, for it appears that only experienced and trained physicians can successfully perform their duties with troop units.<sup>40</sup>

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<sup>40</sup>Christy, Military Medical Officer, p. 241.

## CHAPTER 4

### CONCLUSIONS

And is there anything more important than that the work of the soldier should be well done?

Plato

### Introduction

The purpose of this thesis was to examine the Battalion Surgeon in detail from a number of different perspectives that emerged from the review of literature.

Chapter 1, Introduction, provided a general introduction and background on the Battalion Surgeon and the problem to be studied. The reader was introduced to why the Battalion Surgeon was disestablished, and why the position was reestablished over a decade later. Insights were offered on the impact the new Battalion Surgeon would have on the future. The significance of the study was also established.

Chapter 2, Survey of Literature, was presented in three parts. The intent of Chapter 2 was to present all relevant literature findings pertinent to the Battalion Surgeon. Part I, The Battalion Surgeon, attempted to provide the reader with a comprehensive understanding of the Battalion Surgeon's background, duties and

responsibilities, selection, and work environment. Part II, Training, reported the literature findings concerning the Battalion Surgeon's professional development, his assignment process and a history of his training and education to perform his assigned duties. Part III, Sociology, reported on the special status enjoyed by physicians. The special physician recruitment and retention problems historically faced by the Army Medical Department were also discussed in an attempt to provide the reader with an underlying appreciation of some of the historical problems involved in "soldierizing" physicians, much less Battalion Surgeons.

Chapter 3, Findings, summarized and condensed the major findings into five major areas surfaced by the literature findings and believed to be relevant to a study of the Battalion Surgeon. These five major areas included the reasons and the ramifications produced by the disestablishment of the Battalion Surgeon; the historical and contemporary need established for a Battalion Surgeon; the major duties and responsibilities of the Battalion Surgeon; the military training of the Battalion Surgeon; and finally the professional--both military and clinical--considerations surrounding the Battalion Surgeon.

The method used to develop this thesis combined both a descriptive and historical approach. An attempt was made to identify the interconnection between lessons

learned from the past and the problems facing the new Battalion Surgeon.

### Conclusions

#### General

Although the importance of military training for physicians has been fully recognized, the Army Medical Department has always had to react to national emergencies with insufficiently trained physicians. As evidenced by history, the Army Medical Department has been poorly prepared to provide qualified physicians capable or experienced in field medical support, especially at the maneuver battalion level. The history of American wars has shown that officers, including the Battalion Surgeon, must be highly trained in order to conduct any war successfully. Disastrous results of inadequate military training for the Battalion Surgeon have been observed and can only be measured in lives. The idea of providing physicians with military training is not an original one, but it has suffered general neglect over the past decade and requires calling attention to this neglect and reemphasizing the importance of training and preparation for war.

Possibly good battalion surgeons are born, but certainly many more can be made, and the whole medical organization behind them is dependant upon their ability...<sup>1</sup>

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<sup>1</sup>Conn, Battalion Medical Officer, p. 123.

We cannot buy well trained personnel. We must develop them in our own schools and training centers for their value cannot be estimated in dollars and cents. Rather it will be reckoned in human lives.<sup>2</sup>

#### General Training

Since the close of World War II, the military and medical profession has become more complex. Tactical, logistical and administrative doctrine has changed as rapidly as clinical medicine advances. The Army's Airland Battle doctrine of the 1980's and 1990's calls for a greater integration and devotion of military and medical disciplines. If physicians are going to be depended upon to plan, execute, and supervise the medical support provided to battalions, they must be given the appropriate training. This includes the organization, functions, and tactical employment of all arms of service, including medical, and the organization, training, leadership and tactical employment of the medical platoon.

Physicians serving as Battalion Surgeons need to

understand the responsibility of the line officer and of command, to learn and identify with the mission of his service and to understand, to at least a reasonable degree, the duties, the stresses, and hazards involved for the men in the major segments of the armed services.<sup>3</sup>

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<sup>2</sup>Stout, Why Training?, p.157.

<sup>3</sup>Christy, Military Medical Officer, p. 242.



Summarizing the lessons of history regarding training, the Battalion Surgeon must master several military subjects. These include hygiene, sanitation, drill, map reading, medical tactics, camouflage, cover, concealment, training, training management, leadership, command, marksmanship, administration, logistics accountability and allocation, maintenance, staff procedures, patrolling, scouting, medical intelligence, care and evacuation of the wounded and basic military skills. In summary, an emphasis suggested in the literature is that physicians serving in forward medical units "must be thought of and trained primarily as soldiers."<sup>4</sup>

#### Field Training Emphasis

The serious defect in the training of physicians has historically been the shortening, condensing and sometimes absence of training for operations under field and combat conditions. Successes the Army Medical Department has achieved in its history have been attributed to the "utmost importance of the field training given to medical officers."<sup>5</sup> An important lesson of medical

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<sup>4</sup>Anthony Cotterell, R.A.M.C. (New York: Hutchinson & Co., 1944), p. 69.

<sup>5</sup>Dabney, Medical Field Service School, p. 113.

history is that

Medical officers...must be trained first for what they are to undergo in war. To loose sight of this is to invite disaster.<sup>6</sup>

#### Training , Experience and Command

The idea practiced today that physicians need only a slight amount of exposure, training, and experience with the line to be prepared to command at any level is completely without basis. One key lesson that stands out for the Battalion Surgeon is that if he is to carry out his mission effectively and well, he must be well trained, and an active member within the unit. The Battalion Surgeon cannot be a window dressing in the medical platoon. Unless the Battalion Surgeon is properly trained for the job he is supposed to accomplish, he will merely bear the name "Battalion Surgeon" without knowing how to serve it. This is a lesson well learned and historically founded. Jones, a Colonial surgeon, extorted these beliefs in 1776:

As to those gentlemen, who will neither read nor reason, but practice at a venture, and sport with the lives and limbs of their fellow-creatures, I can only...advise them seriously to pursue the fifth commandment, which is, "Thou Shalt Not Kill."<sup>7</sup>

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<sup>6</sup>Jones, War Again, p. 589.

<sup>7</sup>John Jones, Plain Concise Practical Remarks on the Treatment of Wounds and Fractures (n.p.: Arno Press Inc., 1971), p. 12.

### Problems Implementing

The reintroduction of the Battalion Surgeon will require some reorientation of physician behavior, roles and leadership. Adaptations to standardization, and regimentation and a balancing of clinical, staff, and command roles will be required. The success of the Battalion Surgeon will depend on his motivation for military service, the military training he receives and the role he performs in the combat battalion. If he solely relies on the Medical Service Corps officer, the Physician's Assistant, and others to perform his job, he will disservice himself, the medical platoon and the battalion. Likewise, his lack of proper focus, attitude and training will sour many young career oriented soldiers.

### Contribution of the Study

As best I am able to determine, this thesis represents the first in-depth look at the Battalion Surgeon since even before the position was disestablished over a decade ago. There are no recent and/or definitive books, studies or reports currently available describing the background, need, duties, problems or training involved in reestablishing the Battalion Surgeon.

I believe there are several important contributions made by this study. The first contribution of this study

is that it recounts in one setting the many issues and lessons learned about the Battalion Surgeon as derived from a wide body of historical literature. Second, I believe this thesis raises the consciousness and stimulates the thought process by presenting the diverse and complex interconnecting issues suggested by the reintroduction of the Battalion Surgeon. Third, I hope that this thesis has presented a justified case for providing the Battalion Surgeon with the military training necessary to perform the duties of the medical platoon leader.

#### Suggestions For Further Research

Chapter 1, Introduction, presented some general issues that begged systematic investigation based on the reintroduction of the Battalion Surgeon. I will reiterate them and suggest additional issues that evidenced themselves to me in the course of investigating and reporting on the Battalion Surgeon. Having the experience of this thesis behind me, I believe that any one of the following issues would lend themselves to a study in itself.

Need. Evidence for the need of the Battalion Surgeon was documented from a morale, treatment, evacuation and medical leadership standpoint. I believe a further investigation, by a clinician, into the medical need for a

Battalion Surgeon is warranted. The training and education of the Physician's Assistant has improved since their introduction in 1973; what can or can't Physician's Assistants do in relation to a physician's capabilities?

Specialty Training. Several literature sources suggested that military medicine become a medical specialty in itself. Is there evidence to suggest that military "surgeons" should be separately trained, assigned and developed?

Procurement and Retention. There are a significant quantity of Battalion Surgeon positions in the Army's Tables of Organization and Equipment. Does the AMEDD have enough physicians to fully and creditably reestablish the Battalion Surgeon short of "tokenism?" Have physicians developed positive attitudes about military service since the 1960's? Will physicians reexpress a historical dissatisfaction for battalion duty and will the AMEDD experience traditional recruitment and retention problems as a result?

Medical Service Corps. Having filled the maneuver battalion leadership void left by the Battalion Surgeon over a decade ago, what new role will be created for the Medical Service Corps officer? Could a line officer just as easily support the Battalion Surgeon as an MSC? As the

Battalion Surgeon represents the return of a traditional position, should the MSC officer receive advanced clinical training as he did during World War II, Korea and Vietnam? Can the Medical Service Corps still continue to attract young, aggressive leaders without having the ability to exercise them as platoon leaders in maneuver battalions? What leadership incentives and roles will the Medical Service Corps develop for its officers? Should MSC officers continue to serve as platoon leaders with the responsibility of organizing, training, and leading the medical platoon and allowing the physician to perform the clinical and medical staff duties within the battalion?

Integration. Several interesting studies have inquired into the issue of physician rank. Commissioned as Captains or higher, most physicians enter the Army with higher rank but lower equivalent military training and experience than their peers. This often leads to animosity and misunderstanding between physicians and line officers. Is this animosity and lack of equivalent military training a real factor that inhibits physician effectiveness, especially at the maneuver battalion level? Considering the magnitude, scope, and responsibilities of the Battalion Surgeon's position, should more experienced physicians be assigned as Battalion Surgeons than entry level physicians?

Professional Development. The reintroduction of the Battalion Surgeon calls for an obvious reassessment of both the Medical Corps and Medical Service Corps professional development plan. This inquiry should study and evaluate the system of training and assignments for both groups.

Training. Beyond the training requirements for the Battalion Surgeon presented within the historical review of this thesis, a formal training assessment needs to be conducted. What formal tasks, under what conditions and to what standards will the Battalion Surgeon need to be trained? How will the varied number of service entry programs available for physicians, each with its own degree and proficiency level of pre-commissioning training affect both entry and post-entry level training? What other training courses in the Army School System will integrate with the Battalion Surgeon training program?

Post Assessment. After a period of perhaps five to ten years, it might be worthwhile to study the 1984 decision to reestablish the Battalion Surgeon. Emphasis being to the degree and numbers of physicians actually assigned to Battalion Surgeon positions; the training program provided to Battalion Surgeons in terms of scope, duration, tasks taught, proficiency and standards expected;

the performance of Battalion Surgeons gauged by field commanders reports; and finally, the perceptions and attitudes of Battalion Surgeons and Medical Service Corps officers towards their training, job, recruitment and retention.

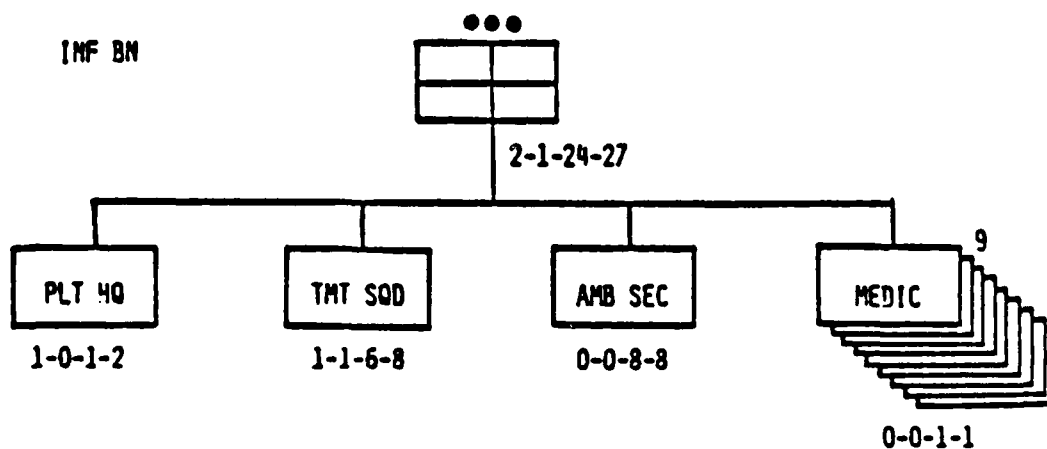


APPENDIX A

## APPENDIX A. Medical Platoon Structure

U.S. Department of the Army. Academy of Health Sciences. Interim Operation Concept: Medical Support in the Light Infantry Division. Draft. Rev 2. (Fort Sam Houston, TX: AHS. [bv Oct 1984]). p. 18.

## UNIT LEVEL MEDICAL SUPPORT



## APPENDIX B

## APPENDIX B. Battlefield Medicine Dicta

U.S. Department of the Army. Academy of Health Sciences. Medical System Program Review. Final Ed. (Fort Sam Houston, TX: AHS. 1984). n.p.

Examination of military medical experience over the past 50 years has underscored the following dicta regarding the practice of battlefield medicine:

- a) Commanders must actively pursue maintenance of health in their commands as an integral part of the conduct of operations
- b) Prevention is the primary means of insuring a healthy combat force.
- c) A soldier's survivability on the battlefield is enhanced by his ability to render first-aid to himself and his buddy.
- d) Physician-directed care far forward on the battlefield ensures maintenance of the casualty's physiology thereby increasing the probability of his early return to duty.
- e) Segregation of patients into return to duty (in theater) and non-return to duty significantly improves the efficiency of medical field units.
- f) Field medical systems ought to be designed to maximize retention in theater of casualties who can be returned-to-duty in theater.
- g) Evacuation and treatment of casualties must be selective.
- h) Long Distance Evacuation following initial surgery is feasible (4-6 hours bed-to-bed).
- i) Evacuation vehicles must be present in the required numbers and controlled by the medical system.

**APPENDIX C**

## APPENDIX C. The Battalion Medical Officer

Harold R. Conn. "The Battalion Medical Officer." The Army Medical Bulletin 61 (April 1942) p. 119-123.

**T**HE battalion medical officer probably enjoys the most individualistic responsibility of any officer in the service. His colleagues attached to sorting stations, ambulance companies, and evacuation hospitals have the advantage of contact and conference, something which may be denied him during periods of military action.

It is obligatory that the battalion officer be young, vigorous, and in perfect health in order to withstand the rigors of accompanying his unit during active campaigning. He must master subjects foreign to his civilian training; to mention a few, these include troop hygiene and sanitation, medical corps training and drill, map reading, orientation, and something of tactics and the art of concealment. Emphasizing only one, the training of his enlisted personnel is a genuine task; and there are many other fields to explore, such as gas-proofing, the selection of sheltered havens where battle casualties may be protected, and finally the problem of feeding the wounded.

He may consider these duties professional inactivity, but there will follow periods when all of his medical acumen will be required and the military demands will be even less exacting than the professional responsibilities. During severe and sustained action he must retain coolness, calmness, and a nicety of surgical judgment under the most adverse conditions. This latter is an indefinable but essential attribute compiled of just the right mixture of a stable nervous system, past surgical experience, common sense, and an ever ready diagnostic ability. It may seem a needless sacrifice, but wars are won only by sending the best men to the front.

The battalion medical officer's responsibilities make demands upon his previous training but these differ widely from his past experience. He most certainly has never before been suddenly confronted with a half gross or more of injuries running the gamut of head, chest, abdomen, and extremities, nor has he ever before worked to the limit of his physical and mental capacities where all about him are chaos and confusion. True, there is little in the routine but essential military training that fits him to meet this sudden and overwhelming activity, but ex-

perience can be simulated by military maneuvers and through special training from his regimental and division surgeons.

In fact, no greater duty rests upon the division surgeon than to see that his first line officers are selected from men who have had some civilian traumatic experience. Even so, they should be taught the routine and correct use of tourniquets and traction splints, the differentiation between traumatic and cerebral shock, and a profound medical appreciation of the effects of dehydration, exposure, and hemorrhage upon wounded men. In this training the time element should be stressed as all important. The rapid collection of wounded and their intelligent dispatch to the rear definitely determines the mortality rate of almost all except the initially fatal injuries. Many of these problems are those which never confront the physician in civilian practice, since the ever ready and fast ambulance delivers the casualty to the hospital receiving room usually within a matter of minutes.

There exists the notion among young medical graduates that an appointment to operative surgical teams and to base hospitals offers opportunities to gain vast experience in chosen specialties, whereas being assigned as a battalion medical officer engenders atrophy of previous knowledge and experience. This is absurdly wrong.

With a few individual exceptions war surgery in World War I taught the physician very little. As a member of an operating team he found the technique of debridement destructive rather than constructive and the type of injury differed greatly from that seen in civilian life. There was, moreover, no opportunity to observe the end results of operations done. In base hospitals the surgery was and will be done by a few men and the junior officer will act as the equivalent of a house officer in a well organized civilian institution. Finally, between the surgical units operating near the field of battle and the combat battalion, there is little or nothing in the way of practical civilian medical experience to be acquired.

The battalion officer, on the contrary, after a period of military training, may some day expect to find himself confronted with a number of injuries which would disorganize the largest civilian hospital in the United States. He may logically anticipate that in a relatively minor engagement ten percent of his men will be casualties and twenty-five percent of these will probably be fatally wounded. The percentage who live or die is positively influenced by his activity and professional skill. It

seems unnecessary and almost stupid to call attention to the fact that obviously moribund patients should not be evacuated from the battalion aid station, yet this very information had to be repeated again and again to the vast majority of battalion surgeons during their early weeks of real action in the last war.

As physicians, all of us have been trained not to usurp the powers of Providence but to attempt to save every life even against impossible odds and to keep trying until life is fully and completely lost. This training cannot entirely function or endure upon the battlefield. Even to the unexperienced medical officer it must be obvious that he will be confronted simultaneously with hopelessly wounded, borderline cases, and with cases where reasonably prompt treatment and evacuation will result in recovery. He must learn under the trying conditions of active combat to recognize the doomed patients and to exercise that same calm impartiality shown by the judiciary when they pass sentence. He must refuse to clutter his limited evacuation facilities with the hopelessly wounded. It is platitudinous to state that, no matter how good the surgical equipment and personnel may be in the rear, they cannot save mortally wounded and dead men. The borderline cases present the real test of ability and many may be saved by proper de-shocking, either prompt mobilization or immobilization awaiting reaction, all depending upon the wound and the response to initial judgment and treatment.

In a lifetime of traumatic surgery the physician could scarcely be called upon to make the decisions demanded daily of the battalion surgeon during such offensives as the Meuse-Argonne. Questions as whether to give more morphine or to withhold it, to continue de-shocking by external heat and posture or attempt to rush the patient to a hospital, to loosen the tourniquet at the risk of death or to leave it tight and sacrifice a limb, to attempt to separate cerebral shock from traumatic shock, and to estimate the degree which cold, fright, dehydration, and exposure aggravated wounds were presented almost by the minute.

These are not flights of fancy but the cold reality which confronts the battalion surgeon hidden in a poorly lighted dug-out or in a shell hole under fire in the dead of night without adequate help, with some of his own stretcher bearers wounded and with the field around him still covered with badly wounded but unrecovered men. It should take but little imagination for the young officer to picture for himself the difference between this scene and the one in the hospital in which he trained, where



an occasional casualty was brought in, where he had adequate professional assistance, superb nursing care, electric lights, and blood transfusion available within ten or fifteen minutes after injury. The officer who feels that his professional talent will be wasted as a battalion surgeon simply hasn't been there.

It should be re-emphasized that he must exercise not only coolness and good sense but shrewd diagnostic acumen under the most adverse conditions without the benefit of counsel and often after twenty-four hours of constant duty.

The morale of any battalion is very positively influenced by the ability and the elan of its medical personnel. Combat troops, however courageous, react splendidly to the knowledge that if wounded and helpless on the field they will somehow be recovered by the medical corps and will receive prompt, adequate, and competent care. The splendid records of many units can be partially credited to the courage and resourcefulness of their supporting medical detachments. There is no place in either civilian or military professional activity where gratitude and devotion are so generously given as to a real doctor in action with combat troops.

After recovery and segregation in the battalion aid station or the collecting station the most common question asked the medical officer by the wounded is, "How seriously am I hit?" or "Am I going to get well?" and the reaction on the part of the patient to a cheerful and reassuring response is one of the amazing phenomena of war wounds. It is second only to the dramatic reaction made by wounded men when placed in de-shocking cabinets and external heat applied.

The statistics as regards the mortality reduction when the application of traction splints on the field in 1915 was made a military order are too well known to need repeating here but the imperative necessity of the application of traction before transportation cannot be overemphasized.

There is no possibility in this short space to discuss the intriguing differentiation in the treatments of exposure, hemorrhage, acidosis, and shock. Books have been written about the signs, symptoms, and treatment of each one individually. The battle casualty presents a combination of all of these and the battalion surgeon will be amazed at the reactions of apparently desperately injured young soldiers to reassurance, traction splinting, morphine, external heat, and hot fluids internally.

The treatment of infections and the chemotherapy of wounds by the use of the sulfonamides likewise present a special problem in instruction.

Once in action the days of drill, sanitary inspections, and foot work are forgotten and the battalion officer becomes again the professional man for which his long training has fitted him and which he has hoped to make his life work. Among medical veterans the expression is common that if they go again they want to serve with troops, and it is not only the excitement but the actual professional responsibility which intrigues them.

Possibly good battalion surgeons are born, but certainly many can be made, and the whole medical organization behind them is dependent upon their ability, while ahead of them the Army actually places its trust and its lives in their hands.

HAROLD R. CONN, M.D.,  
Akron, Ohio.

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Thos. Fuller: All things are difficult before they are easy.

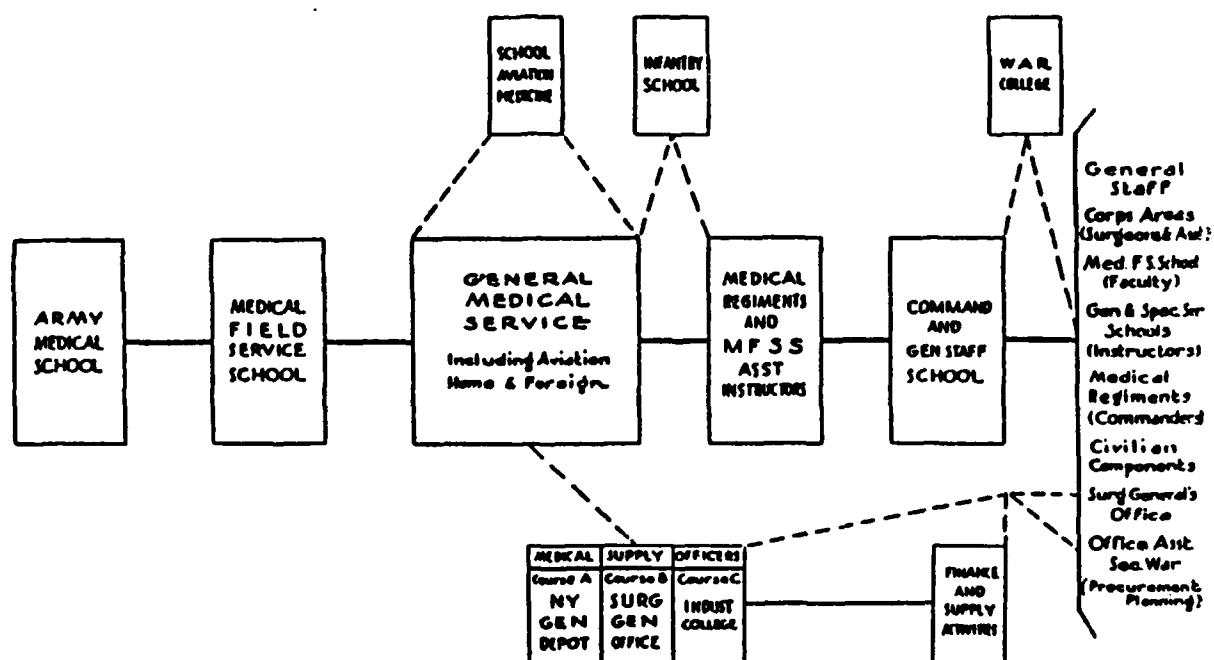
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## APPENDIX D

## APPENDIX D. 1930 Training Plan

C.R. Reynolds. "The Training of Medical Officers at Service Schools." The Army Medical Bulletin 1:2 (April 1930) p. 4.

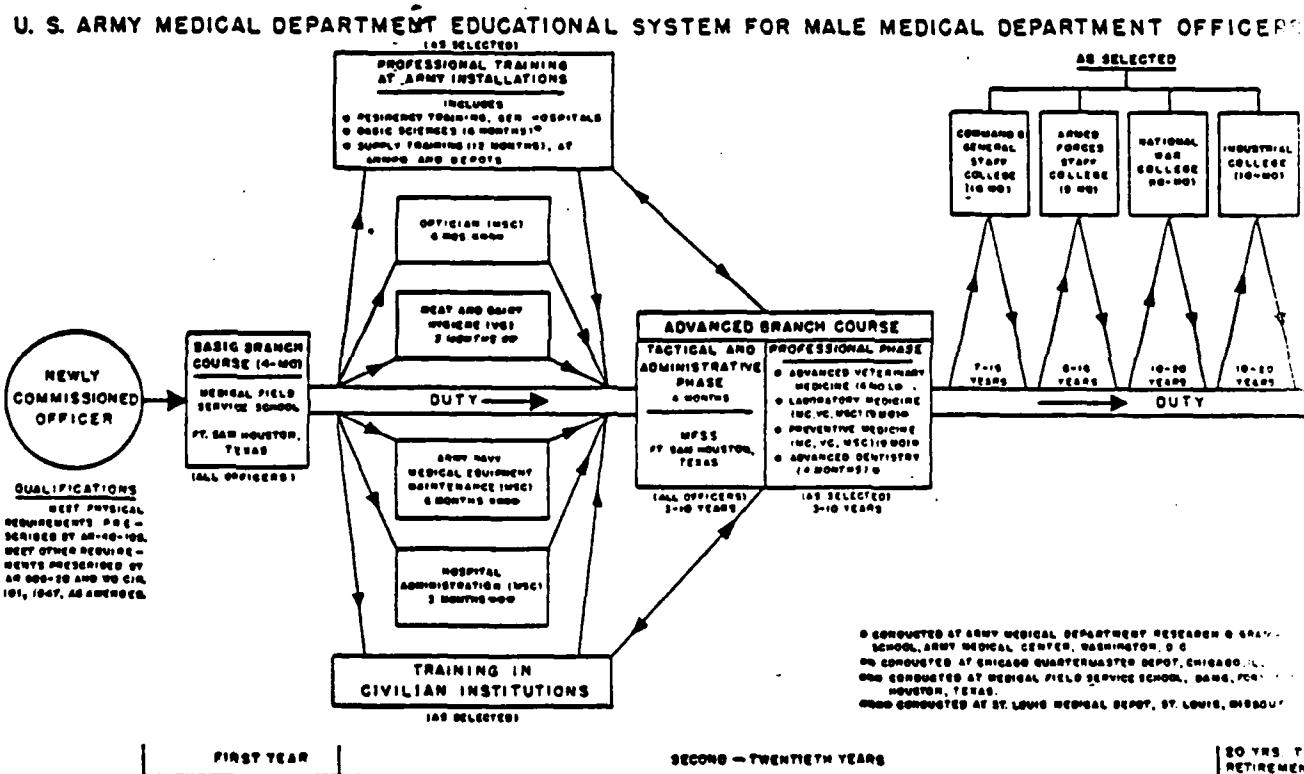
## TRAINING OF MEDICAL OFFICERS AT SERVICE SCHOOLS AND EMPLOYMENT OF GRADUATES



**APPENDIX E**

## APPENDIX E. Medical Department Educational System

Raymond E. Duke, "The Training of Officers in the Medical Department." The Bulletin of the U.S. Army Medical Department 8:5 (May 1948) p. 381.



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